

# Application for a §1915(c) Home and Community-Based Services Waiver

## PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a state to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waivers target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the state, service delivery system structure, state goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

## Request for an Amendment to a §1915(c) Home and Community-Based Services Waiver

### 1. Request Information

A. The **State** of **Kansas** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.

B. **Program Title:**

Autism Waiver

C. **Waiver Number:**KS.0476

D. **Amendment Number:**KS.0476.R02.05

E. **Proposed Effective Date:** (mm/dd/yy)

07/01/21

**Approved Effective Date of Waiver being Amended:** 04/01/17

### 2. Purpose(s) of Amendment

**Purpose(s) of the Amendment.** Describe the purpose(s) of the amendment:

The Kansas State Legislature approved an increase to the Protected Income Level to 300% of Supplemental Security Income. This amendment is to allow for waiver participants to gain access to the new Protected Income Level. The state sees no adverse effects to waiver participants.

### 3. Nature of the Amendment

A. **Component(s) of the Approved Waiver Affected by the Amendment.** This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently (*check each that applies*):

Component of the Approved Waiver	Subsection(s)
Waiver Application	
Appendix A Waiver Administration and Operation	

Component of the Approved Waiver	Subsection(s)
Appendix B Participant Access and Eligibility	<input type="text"/>
Appendix C Participant Services	<input type="text"/>
Appendix D Participant Centered Service Planning and Delivery	<input type="text"/>
Appendix E Participant Direction of Services	<input type="text"/>
Appendix F Participant Rights	<input type="text"/>
Appendix G Participant Safeguards	<input type="text"/>
Appendix H	<input type="text"/>
Appendix I Financial Accountability	<input type="text"/>
Appendix J Cost-Neutrality Demonstration	<input type="text"/>

**B. Nature of the Amendment.** Indicate the nature of the changes to the waiver that are proposed in the amendment (*check each that applies*):

**Modify target group(s)**

**Modify Medicaid eligibility**

**Add/delete services**

**Revise service specifications**

**Revise provider qualifications**

**Increase/decrease number of participants**

**Revise cost neutrality demonstration**

**Add participant-direction of services**

**Other**

Specify:

## Application for a §1915(c) Home and Community-Based Services Waiver

### 1. Request Information (1 of 3)

**A. The State of Kansas** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

**B. Program Title** (optional - this title will be used to locate this waiver in the finder):

Autism Waiver

**C. Type of Request:** amendment

**Requested Approval Period:** (For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)

3 years      5 years

**Waiver Number:** KS.0476.R02.05

**Draft ID:** KS.004.02.04

**D. Type of Waiver** (select only one):

Regular Waiver

**E. Proposed Effective Date of Waiver being Amended:** 04/01/17

**Approved Effective Date of Waiver being Amended:** 04/01/17

### PRA Disclosure Statement

The purpose of this application is for states to request a Medicaid Section 1915(c) home and community-based services (HCBS) waiver. Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so that a state may voluntarily offer HCBS to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: December 31, 2023). The time required to complete this information collection is estimated to average 160 hours per response for a new waiver application and 75 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

## 1. Request Information (2 of 3)

**F. Level(s) of Care.** This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid state plan (check each that applies):

### **Hospital**

Select applicable level of care

#### **Hospital as defined in 42 CFR §440.10**

If applicable, specify whether the state additionally limits the waiver to subcategories of the hospital level of care:

**Inpatient psychiatric facility for individuals age 21 and under as provided in 42 CFR §440.160**

### **Nursing Facility**

Select applicable level of care

**Nursing Facility as defined in 42 CFR ??440.40 and 42 CFR ??440.155**

If applicable, specify whether the state additionally limits the waiver to subcategories of the nursing facility level of care:

**Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140****Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**

If applicable, specify whether the state additionally limits the waiver to subcategories of the ICF/IID level of care:

**1. Request Information (3 of 3)**

**G. Concurrent Operation with Other Programs.** This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

**Not applicable**

**Applicable**

Check the applicable authority or authorities:

**Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**

**Waiver(s) authorized under §1915(b) of the Act.**

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

**Specify the §1915(b) authorities under which this program operates (check each that applies):**

**§1915(b)(1) (mandated enrollment to managed care)**

**§1915(b)(2) (central broker)**

**§1915(b)(3) (employ cost savings to furnish additional services)**

**§1915(b)(4) (selective contracting/limit number of providers)**

**A program operated under §1932(a) of the Act.**

Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

**A program authorized under §1915(i) of the Act.**

**A program authorized under §1915(j) of the Act.**

**A program authorized under §1115 of the Act.**

*Specify the program:*

**H. Dual Eligibility for Medicaid and Medicare.**

Check if applicable:

**This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

## 2. Brief Waiver Description

**Brief Waiver Description.** *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The purpose of the Kansas Autism Waiver is to provide eligible Kansans the option to receive parental support in their home and community in a cost-efficient manner. The goal of the Autism Waiver is to divert children from entering an inpatient psychiatric facility for individuals age 21 and under as provided in 42CFR440.160 by providing parental support and training. Autism Waiver services are available to children who have received a diagnosis of an Autism Spectrum Disorder (ASD), including Autism, Asperger Syndrome, and Other Pervasive Developmental Disorder-Not Otherwise Specified from a licensed Medical Doctor or Ph.D. Psychologist using an approved Autism specific screening tool. Since research has shown that early intensive interventions with ASD children are effective, a child must be between the age of zero through their fifth year of age upon entering the waiver and be financially eligible for Medicaid. Children must also meet the Level of Care eligibility determination conducted initially and annually by a qualified Functional Eligibility Specialist. The level of care instrument used to determine initial and annual eligibility for the Autism waiver must be the state approved functional eligibility instrument. The Kansas Autism Waiver has a service limit of three years with a one time, one year extension possible. The Kansas Autism Waiver provides three distinctive services to participants and their families. These services are: Respite Care, Parent Support and Training (peer to peer) Provider, and Family Adjustment Counseling.

Once a child has completed the three (3) years of service or when approved four (4) years of service or been found to be no longer eligible for the HCBS Autism Waiver, the child may transition to which ever waiver the family and child feels will meet the needs of the child and that the child meet functional eligibility for. In the case of each waiver:

HCBS Intellectual and Developmental Disability (I/DD): If the child meets the eligibility criteria, as determined by the IDD waiver, for the IDD waiver they may bypass the waitlist during their transition.

HCBS Severe Emotional Disturbance (SED): If the child meets the eligibility criteria, as determined by the SED waiver, the child may transition to the SED waiver.

HCBS Technology Assistance (TA): If the child meets the eligibility criteria, as determined by the TA waiver, the child may transition to the TA waiver.

Each waiver participant will have a plan of care (POC). The POC is developed by the Managed Care Organization (MCO) and will describe waiver services the child is to receive, their frequency, and the type of provider who is to furnish each service. All waiver services will be furnished pursuant to a written plan of care. The plan of care will be subject to the approval by the selected KanCare MCO. Federal Financial Participation (FFP) will not be claimed for waiver services which are not included in the child's written plan of care.

Programmatic oversight and control of the waiver is provided by Kansas Department for Aging and Disability Services (KDADS). KDADS has taken the necessary safeguards to protect the health and welfare of children receiving services under this waiver by setting adequate standards for all types of providers that furnish HCBS/Autism waiver services; those standards of any State licensure or certification requirements are met for services or for individuals furnishing services through the waiver.

## 3. Components of the Waiver Request

**The waiver application consists of the following components. Note: Item 3-E must be completed.**

**A. Waiver Administration and Operation.** Appendix A specifies the administrative and operational structure of this waiver.

**B. Participant Access and Eligibility.** Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the state expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

**C. Participant Services.** Appendix C specifies the home and community-based waiver services that are furnished through

the waiver, including applicable limitations on such services.

**D. Participant-Centered Service Planning and Delivery.** **Appendix D** specifies the procedures and methods that the state uses to develop, implement and monitor the participant-centered service plan (of care).

**E. Participant-Direction of Services.** When the state provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

**Yes. This waiver provides participant direction opportunities. Appendix E is required.**

**No. This waiver does not provide participant direction opportunities. Appendix E is not required.**

**F. Participant Rights.** **Appendix F** specifies how the state informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

**G. Participant Safeguards.** **Appendix G** describes the safeguards that the state has established to assure the health and welfare of waiver participants in specified areas.

**H. Quality Improvement Strategy.** **Appendix H** contains the Quality Improvement Strategy for this waiver.

**I. Financial Accountability.** **Appendix I** describes the methods by which the state makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

**J. Cost-Neutrality Demonstration.** **Appendix J** contains the state's demonstration that the waiver is cost-neutral.

#### 4. Waiver(s) Requested

**A. Comparability.** The state requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid state plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

**B. Income and Resources for the Medically Needy.** Indicate whether the state requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy (*select one*):

**Not Applicable**

**No**

**Yes**

**C. Statewide.** Indicate whether the state requests a waiver of the statewide requirements in §1902(a)(1) of the Act (*select one*):

**No**

**Yes**

If yes, specify the waiver of statewide requirements that is requested (*check each that applies*):

**Geographic Limitation.** A waiver of statewide requirements is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the state. *Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:*

**Limited Implementation of Participant-Direction.** A waiver of statewide requirements is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the state. Participants who reside in these areas may elect to direct their services as provided by the state or receive comparable services through the service delivery methods that are in effect elsewhere in the state. *Specify the areas of the state affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:*

## 5. Assurances

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In accordance with 42 CFR §441.302, the state provides the following assurances to CMS:

- A. Health & Welfare:** The state assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:
1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
  2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,
  3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.
- B. Financial Accountability.** The state assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.
- C. Evaluation of Need:** The state assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.
- D. Choice of Alternatives:** The state assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:
1. Informed of any feasible alternatives under the waiver; and,
  2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the state employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.
- E. Average Per Capita Expenditures:** The state assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid state plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.
- F. Actual Total Expenditures:** The state assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.
- G. Institutionalization Absent Waiver:** The state assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.
- H. Reporting:** The state assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid state plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.
- I. Habilitation Services.** The state assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the

Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

**J. Services for Individuals with Chronic Mental Illness.** The state assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the state has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

## 6. Additional Requirements

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*Note: Item 6-I must be completed.*

- A. Service Plan.** In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including state plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.
- B. Inpatients.** In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.
- C. Room and Board.** In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the state that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.
- D. Access to Services.** The state does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the state has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.
- G. Fair Hearing:** The state provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the state's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.
- H. Quality Improvement.** The state operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the state assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The state further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the state will implement the Quality Improvement Strategy specified in **Appendix H**.



**I. Public Input.** Describe how the state secures public input into the development of the waiver:

A public notice was not required as this is not a substantive change. The Tribal Notice was posted June 10, 2021 and ended June 24, 2021.  
The Tribal Notice did not elicit any comments.

**J. Notice to Tribal Governments.** The state assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

**K. Limited English Proficient Persons.** The state assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the state assures meaningful access to waiver services by Limited English Proficient persons.

## 7. Contact Person(s)

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**A.** The Medicaid agency representative with whom CMS should communicate regarding the waiver is:**Last Name:**

Graff-Hendrixson

**First Name:**

Bobbie

**Title:**

Senior Manager - Contracts, SPAs, Regulations and SFHs

**Agency:**

Kansas Department of Health and Environment

**Address:**

900 SW Jackson

**Address 2:**

Room 900 N

**City:**

Topeka

**State:**

Kansas

**Zip:**

66612-1220

**Phone:**

(785) 296-0149

**Ext:**

TTY

**Fax:**

(785) 296-4813

**E-mail:**

Bobbie.Graff-Hendrixson@ks.gov

**B.** If applicable, the state operating agency representative with whom CMS should communicate regarding the waiver is:

<b>Last Name:</b>	<input type="text" value="Sam"/>
<b>First Name:</b>	<input type="text" value="Philbern"/>
<b>Title:</b>	<input type="text" value="Program Manager"/>
<b>Agency:</b>	<input type="text" value="Kansas Department for Aging and Disability Services"/>
<b>Address:</b>	<input type="text" value="503 S. Kansas Ave."/>
<b>Address 2:</b>	<input type="text"/>
<b>City:</b>	<input type="text" value="Topeka"/>
<b>State:</b>	<b>Kansas</b>
<b>Zip:</b>	<input type="text" value="66603-3404"/>
<b>Phone:</b>	<input type="text" value="(785) 296-6843"/> Ext: <input type="text"/> TTY
<b>Fax:</b>	<input type="text" value="(785) 296-0256"/>
<b>E-mail:</b>	<input type="text" value="samuel.philbern@ks.gov"/>

## 8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the state's request to amend its approved waiver under §1915(c) of the Social Security Act. The state affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The state further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The state certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

**Signature:**

State Medicaid Director or Designee

**Submission Date:**

**Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.**

**Last Name:**

**First Name:**

**Title:**

	<div>Waiver Program Manager</div>		
Agency:	<div>KDHE</div>		
Address:	<div>900 SW Jackson Avenue, Suite 900 N</div>		
Address 2:	<div></div>		
City:	<div>topeka</div>		
State:	<div>Kansas</div>		
Zip:	<div>66612</div>		
Phone:	<div>(785) 296-8623</div>	Ext: <div></div>	TTY
Fax:	<div>(785) 296-4813</div>		
E-mail:	<div></div>		
<b>Attachments</b>	<div>Kurt.Weiter@ks.gov</div>		

**Attachment #1: Transition Plan**

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

**Replacing an approved waiver with this waiver.**

**Combining waivers.**

**Splitting one waiver into two waivers.**

**Eliminating a service.**

**Adding or decreasing an individual cost limit pertaining to eligibility.**

**Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**

**Reducing the unduplicated count of participants (Factor C).**

**Adding new, or decreasing, a limitation on the number of participants served at any point in time.**

**Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.**

**Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

The impact of the PIL change will have no negative impact on waiver enrollees.

**Attachment #2: Home and Community-Based Settings Waiver Transition Plan**

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

*Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.*

*To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this*

06/30/2021

waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.

Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.

Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

The state assures that this waiver amendment or renewal will be subject to any provisions or requirements included in the state's most recent and/or approved home and community-based settings Statewide Transition Plan. The state will implement any required changes by the end of the transition period as outlined in the home and community-based settings Statewide Transition Plan.

## Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

N/A

## Appendix A: Waiver Administration and Operation

**1. State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver (*select one*):

**The waiver is operated by the state Medicaid agency.**

Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program (*select one*):

**The Medical Assistance Unit.**

Specify the unit name:

(Do not complete item A-2)

**Another division/unit within the state Medicaid agency that is separate from the Medical Assistance Unit.**

Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

(Complete item A-2-a).

**The waiver is operated by a separate agency of the state that is not a division/unit of the Medicaid agency.**

Specify the division/unit name:

Kansas Department for Aging and Disability Services/Community Services and Programs Commission

In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. (Complete item A-2-b).

## Appendix A: Waiver Administration and Operation

**2. Oversight of Performance.**

**a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:

**As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.**

--

**b. Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

Kansas Department of Health and Environment (KDHE), which is the single state Medicaid agency (SSMA), and the Kansas Department for Aging and Disability Services (KDADS) have an interagency agreement which, among other things:

- Specifies that the SSMA is the final authority on compensatory Medicaid costs.
- Recognizes the responsibilities imposed upon the SSMA as the agency authorized to administer the Medicaid program, and the importance of ensuring that the SSMA retains final authority necessary to discharge those responsibilities.
- Requires the SSMA approve all new contracts, MOUs, grants or other similar documents that involve the use of Medicaid funds.
- Notes that the agencies will work in collaboration for the effective and efficient operation of Medicaid health care programs, including the development and implementation of all program policies, and for the purpose of compliance with all required reporting and auditing of Medicaid programs.
- Requires the SSMA to provide KDADS with professional assistance and information, and both agencies to have designated liaisons to coordinate and collaborate through the policy implementation process.
- Delegates to KDADS the authority for administering and managing certain Medicaid-funded programs, including those covered by this waiver application.
- Specifies that the SSMA has final approval of regulations; SPAs and MMIS policies; is responsible for the policy process; and is responsible for the submission of applications/amendments to CMS in order to secure and maintain existing and proposed waivers, with KDADS furnishing information, recommendations and participation. (The submission of this waiver application is an operational example of this relationship. Core concepts were developed through collaboration among program and operations staff from both the SSMA and KDADS; functional pieces of the waiver were developed collectively by KDHE and KDADS staff; and overview/approval of the submission was provided by the SSMA, after review by key administrative and operations staff and approval of both agencies' leadership.)

In addition to leadership-level meetings to address guiding policy and system management issues (both ongoing periodic meetings and as needed, issue-specific discussions), the SSMA ensures that KDADS performs assigned operational and administrative functions by the following means:

- a. Regular meetings are held by the SSMA with representatives from KDADS to discuss:
  - Information received from CMS;
  - Proposed policy changes;
  - Waiver amendments and changes;
  - Data collected through the quality review process
  - Eligibility, numbers of participants being served
  - Fiscal projections; and
  - Any other topics related to the waivers and Medicaid.
- b. All policy changes related to the waivers are approved by KDHE. This process includes a face to face meeting with KDHE staff.
- c. Waiver renewals, 372 reports, any other federal reporting requirements, and requests for waiver amendments must be approved by KDHE.
- d. Correspondence with CMS is copied to KDHE.

Kansas Department of Health and Environment, as the single state Medicaid agency, has oversight responsibilities for all Medicaid programs, including direct involvement or review of all functions related to HCBS waivers. In addition, under the KanCare program, the HCBS waiver programs have merged into comprehensive managed care. KDHE has oversight of all portions of the KanCare program and the KanCare MCO contracts, and collaborates with KDADS regarding HCBS program management, including those items identified in part (a) above. The key component of that collaboration is through the interagency monitoring team, an important part of the overall state's KanCare Quality Improvement Strategy, which provides quality review and monitoring of all aspects of the KanCare program – engaging program management, contract management, and financial management staff from both KDHE and KDADS.

The services in this waiver are part of the state's KanCare comprehensive Medicaid managed care program. The quality monitoring and oversight for that program, and the interagency monitoring (including the SSMA's monitoring of delegated functions to the Operating Agency) are guided by the KanCare Quality Improvement Strategy. A critical component of that strategy is the engagement of the interagency monitoring team, which will bring together leadership, program management, contract management, fiscal management and other staff/resources to collectively monitor the extensive reporting, review results and other quality information and data related to the KanCare program and services. Because of the managed care structure, and the integrated

focus of service delivery/care management, the core monitoring processes – including interagency monitoring team meetings – are on a quarterly basis. While continuous monitoring will be conducted, including on monthly and other intervals, the aggregation, analysis and trending processes are built around that quarterly structure.

The frequency of oversight is monitored through the joint Long Term Care meeting between the Single State Medicaid Agency and the State Operating Agency, which convenes, at a minimum, monthly.

The interagency agreement between KDHE and KDADS is an evergreen agreement. This agreement is reviewed on a yearly basis by both agencies to determine if edits and changes are needed.

## Appendix A: Waiver Administration and Operation

**3. Use of Contracted Entities.** Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

**Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**

Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

KDADS has contracted with one provider who acts as the entry point for the Waiver services across the state. The contracted entity conducts the level of care determination utilizing the state approved functional eligibility instrument (FEI). The provider also disseminates information to potential children/families, makes referrals to appropriate providers, and conducts assessments and re-assessments.

The state's contracted Managed Care Organizations (MCO) are responsible for ensuring paid support staff or other professionals carry out the plan of care that supports the child's functional development and inclusion in the community. The state's contracted MCOs conduct plan of care development and related service authorizations, develop and review service plans, assist with utilization management, conduct provider credentialing, develop provider manuals, and other provider guidance; and participate in the comprehensive state quality improvement strategy for the KanCare program including this waiver.

**No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

## Appendix A: Waiver Administration and Operation

**4. Role of Local/Regional Non-State Entities.** Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

**Not applicable**

**Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions.

Check each that applies:

**Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

*Specify the nature of these agencies and complete items A-5 and A-6:*

**Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private

entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

*Specify the nature of these entities and complete items A-5 and A-6:*

## Appendix A: Waiver Administration and Operation

- 5. Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

Kansas Department for Aging and Disability Services/ Community Services and Programs Commission

## Appendix A: Waiver Administration and Operation

- 6. Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

Contracted entities, including both contracted entities/providers and the state's KanCare managed care organizations, are monitored through the State's KanCare Quality Improvement Strategy, which provides quality review and monitoring of all aspects of the KanCare program – engaging program management, contract management, and financial management staff from both KDHE and KDADS. All functions delegated to contracted entities are included in the State's comprehensive quality strategy review processes. A key component of that monitoring and review process will be the interagency monitoring team, which will include HCBS waiver management staff from KDADS. In addition, the SSMA and the State operating agency continue to operate collaboratively under an interagency agreement, as addressed in part A.2.b above, and that agreement includes oversight and monitoring of all HCBS programs, the KanCare MCOs and independent assessment contractors.

The KanCare Quality Improvement Strategy and interagency agreements/monitoring teams ensure that the entities contracting with KDADS (the Waiver Operating Agency) are operating within the established parameters. These parameters include CMS rules/guidelines, the approved KanCare managed care contracts and related 1115 waiver, Kansas statutes and regulations, and related policies. Included in the QIS is an ongoing assessment of the results of onsite monitoring and in-person reviews with a sample of HCBS waiver participants. The interagency monitoring team meets quarterly.

## Appendix A: Waiver Administration and Operation

- 7. Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity
Participant waiver enrollment			



Function	Medicaid Agency	Other State Operating Agency	Contracted Entity
Waiver enrollment managed against approved limits			
Waiver expenditures managed against approved levels			
Level of care evaluation			
Review of Participant service plans			
Prior authorization of waiver services			
Utilization management			
Qualified provider enrollment			
Execution of Medicaid provider agreements			
Establishment of a statewide rate methodology			
Rules, policies, procedures and information development governing the waiver program			
Quality assurance and quality improvement activities			

## Appendix A: Waiver Administration and Operation

### Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

#### a. Methods for Discovery: Administrative Authority

*The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.*

#### i. Performance Measures

*For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. As necessary and applicable, performance measures should focus on:*

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

*Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

#### Performance Measure:

Number and percent of Long-Term Care meetings that were represented by the program managers through in-person attendance or written reports  
 $N = \text{Number of Long-Term Care meetings that were represented by the program managers through in-person attendance or written reports}$   
 $D = \text{Number of Long-Term Care meetings}$

**Data Source** (Select one):**Other**

If 'Other' is selected, specify:

**Meeting minutes**

<b>Responsible Party for data collection/generation</b> ( <i>check each that applies</i> ):	<b>Frequency of data collection/generation</b> ( <i>check each that applies</i> ):	<b>Sampling Approach</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
<b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<b>Annually</b>	<b>Stratified</b> Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:	<b>Annually</b>

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="text"/>	
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

Number and percent of Quality Review reports generated by KDADS, the Operating Agency, that were submitted to the State Medicaid Agency  
 $N = \text{Number of Quality Review reports generated by KDADS, the Operating Agency, that were submitted to the State Medicaid Agency}$   
 $D = \text{Number of Quality Review reports}$

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Quality Review Reports**

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text"/>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>

		<input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

Number and percent of waiver policy changes that were submitted to the State Medicaid Agency prior to implementation by the Operating Agency N=Number of waiver policy changes that were submitted to the State Medicaid Agency prior to implementation by the Operating Agency D=Number of waiver policy changes implemented by the Operating Agency

**Data Source** (Select one):**Other**

If 'Other' is selected, specify:

**Presentation of waiver policy changes**

<b>Responsible Party for data collection/generation</b> ( <i>check each that applies</i> ):	<b>Frequency of data collection/generation</b> ( <i>check each that applies</i> ):	<b>Sampling Approach</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>

<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text"/>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):

**Performance Measure:**

Number and percent of waiver amendments and renewals reviewed and approved by the State Medicaid Agency prior to submission to CMS by the State Medicaid Agency

N=Number of waiver amendments and renewals reviewed and approved by the State Medicaid Agency prior to submission to CMS D=Total number of waiver amendments and renewals

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Number of waiver amendments and renewals**

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text"/>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify:	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Kansas Department of Health and Environment, Division of Health Care Finance (KDHE), the single state Medicaid agency, and Kansas Department for Aging and Disability Services (KDADS) work together to develop state operating agency priority identification regarding all waiver assurances and minimum standards/basic assurances. The state agencies work in partnership with participants, advocacy organizations, provider groups and other interested stakeholders to monitor the state quality strategy and performance standards and discuss priorities for remediation and improvement. The state quality improvement strategy includes protocols to review cross-service system data to identify trends and opportunities for improvement related to all Kansas waivers, policy and procedure development and systems change initiatives.

Data gathered by KDADS Regional Staff during the Quality Survey Process is compiled quarterly for evaluation and trending to identify areas for improvement. Upon completion of identified areas of improvement this information is compiled into reports and shared both internally and externally, including with KDHE. As part of the KanCare program, staff of the three MCOs are engaged with state staff to ensure strong understanding of Kansas' waiver programs and the quality measures associated with each waiver program. These measures and collection/reporting protocols, together with others that are part of the KanCare MCO contract, are included in a statewide comprehensive KanCare quality improvement strategy which is regularly reviewed and adjusted. That plan is contributed to and monitored through a state interagency monitoring team, which includes program managers, fiscal staff and other relevant staff/resources from both the state Medicaid agency and the state operating agency.

**b. Methods for Remediation/Fixing Individual Problems**

- i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

State staff and/or KanCare MCO staff request, approve, and assure implementation of provider corrective action planning and/or technical assistance to address non-compliance with waiver and performance standards as detected through on-site monitoring, survey results and other performance monitoring. These processes are monitored by both program managers and other relevant state and MCO staff, depending upon the type of issue involved, and results tracked consistent with the statewide quality improvement strategy and the operating protocols of the interagency monitoring team.

Monitoring and survey results are compiled, trended, reviewed, and disseminated consistent with protocols identified in the statewide quality improvement strategy. Each provider receives annual data trending which identifies Provider specific performance levels related to statewide performance standards and statewide averages. Corrective Action Plan requests, technical assistance and/or follow-up to remediate negative trending are included in annual reports where negative trending is evidenced.

## ii. Remediation Data Aggregation

### Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party( <i>check each that applies</i> ):	Frequency of data aggregation and analysis ( <i>check each that applies</i> ):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div></div>	Annually
	Continuously and Ongoing
	Other Specify: <div></div>

## c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

## Appendix B: Participant Access and Eligibility

### B-1: Specification of the Waiver Target Group(s)

- a. Target Group(s).** Under the waiver of Section 1902(a)(10)(B) of the Act, the state limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals*



served in each subgroup:

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age			
				Maximum Age Limit	No Maximum Age Limit		
Aged or Disabled, or Both - General							
		Aged					
		Disabled (Physical)					
		Disabled (Other)					
Aged or Disabled, or Both - Specific Recognized Subgroups							
		Brain Injury					
		HIV/AIDS					
		Medically Fragile					
		Technology Dependent					
Intellectual Disability or Developmental Disability, or Both							
		Autism		0		5	
		Developmental Disability					
		Intellectual Disability					
Mental Illness							
		Mental Illness					
		Serious Emotional Disturbance					

**b. Additional Criteria.** The state further specifies its target group(s) as follows:

To be eligible for the HCBS/Autism Waiver services, the child must have a diagnosis of Autism Spectrum Disorder, (ASD) including Autism, Asperger Syndrome, and Other Pervasive Developmental Disorder-Not Otherwise Specified from a Medical Doctor or Ph.D. Psychologist. The State relies on Ph.D. level psychologists or a licensed physician for a diagnosis of an Autism Spectrum Disorder and the most appropriate diagnostic tools that they use based on their observations. The diagnosis is supplied to KDADS along with applicable supporting documentation.

A child's services shall be limited to three years, services may be extended for one year with approval of the review team.

**c. Transition of Individuals Affected by Maximum Age Limitation.** When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit (*select one*):

**Not applicable. There is no maximum age limit**

**The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

*Specify:*

If the child will require additional waiver services after exiting the HCBS/Autism Waiver the KanCare MCO will assist the child/family in gaining access to other waiver services. The family may choose to transition the child to the HCBS/IDD waiver, HCBS/SED waiver, or HCBS/TA waiver, providing the established criteria for the waiver is met by the child. The KanCare MCO will contact the appropriate agency 6 months prior to the child transitioning off the HCBS/Autism waiver to develop a transition plan to the appropriate waiver.

Children may utilize services provided through the IDEA program, Kan-Be Healthy (EPSDT), their regional Community Developmental Disabilities Organization (CDDO), an IEP through the public school system, or other available programs. Children meeting program-specific eligibility requirements may receive appropriate services through the Early Childhood Intervention Programs (ECI), the Local Education Agency (LEA) program or services meeting the medical necessity criteria under EPSDT provisions.

A child may be offered services prior to turning age six (6). Children on the Autism Waiver may potentially be served through age 10. All children regardless of their age upon entering the waiver are given the possibility of a one (1) year extension. There are no other exceptions at this time.

## Appendix B: Participant Access and Eligibility

### B-2: Individual Cost Limit (1 of 2)

**a. Individual Cost Limit.** The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual (*select one*). Please note that a state may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

**No Cost Limit.** The state does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*

**Cost Limit in Excess of Institutional Costs.** The state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state. *Complete Items B-2-b and B-2-c.*

**The limit specified by the state is (*select one*)**

**A level higher than 100% of the institutional average.**

Specify the percentage:

**Other**

*Specify:*

**Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*

**Cost Limit Lower Than Institutional Costs.** The state refuses entrance to the waiver to any otherwise qualified individual when the state reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the state that is less than the cost of a level of care specified for the waiver.

*Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.*

The cost limit specified by the state is *(select one)*:

The following dollar amount:

Specify dollar amount:

The dollar amount *(select one)*

Is adjusted each year that the waiver is in effect by applying the following formula:

Specify the formula:

May be adjusted during the period the waiver is in effect. The state will submit a waiver amendment to CMS to adjust the dollar amount.

The following percentage that is less than 100% of the institutional average:

Specify percent:

Other:

Specify:

## Appendix B: Participant Access and Eligibility

### B-2: Individual Cost Limit (2 of 2)

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

- b. Method of Implementation of the Individual Cost Limit.** When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

- c. Participant Safeguards.** When the state specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the state has established the following safeguards to avoid an adverse impact on the participant *(check each that applies)*:

The participant is referred to another waiver that can accommodate the individual's needs.

Additional services in excess of the individual cost limit may be authorized.

Specify the procedures for authorizing additional services, including the amount that may be authorized:

**Other safeguard(s)**

Specify:

**Appendix B: Participant Access and Eligibility****B-3: Number of Individuals Served (1 of 4)**

- a. Unduplicated Number of Participants.** The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The state will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

**Table: B-3-a**

Waiver Year	Unduplicated Number of Participants
Year 1	82
Year 2	82
Year 3	82
Year 4	82
Year 5	82

- b. Limitation on the Number of Participants Served at Any Point in Time.** Consistent with the unduplicated number of participants specified in Item B-3-a, the state may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the state limits the number of participants in this way: *(select one)* :

**The state does not limit the number of participants that it serves at any point in time during a waiver year.**

**The state limits the number of participants that it serves at any point in time during a waiver year.**

The limit that applies to each year of the waiver period is specified in the following table:

**Table: B-3-b**

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	65
Year 2	65
Year 3	65
Year 4	65
Year 5	65

## Appendix B: Participant Access and Eligibility

### B-3: Number of Individuals Served (2 of 4)

**c. Reserved Waiver Capacity.** The state may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State (*select one*):

**Not applicable. The state does not reserve capacity.**

**The state reserves capacity for the following purpose(s).**

Purpose(s) the state reserves capacity for:

Purposes	
Military Inclusion	
Temporary Institutional Stay	

## Appendix B: Participant Access and Eligibility

### B-3: Number of Individuals Served (2 of 4)

**Purpose** (*provide a title or short description to use for lookup*):

Military Inclusion

**Purpose** (*describe*):

The State reserves capacity for dependents and immediate family members of military personnel who have been determined program eligible to bypass waitlist upon approval by KDADS. In the event Kansas instituted a waitlist, individuals who have been determined to meet the established Autism waiver criteria will be allowed to bypass the waitlist and access services.

**Describe how the amount of reserved capacity was determined:**

i. There is no data to support this projection of reserved capacity. If the amount of need exceeds reserve capacity, Kansas will submit an amendment to appropriately reflect the number unduplicated persons served.

**The capacity that the State reserves in each waiver year is specified in the following table:**

Waiver Year	Capacity Reserved
Year 1	2
Year 2	2
Year 3	2
Year 4	2
Year 5	2

## Appendix B: Participant Access and Eligibility

### B-3: Number of Individuals Served (2 of 4)

**Purpose** (provide a title or short description to use for lookup):

Temporary Institutional Stay

**Purpose** (describe):

The state reserves capacity to maintain continued waiver eligibility for participants who enters into an institution such as hospitals or ICF/ID for the purpose of seeking treatment for acute, habilitative or rehabilitative conditions on a temporary basis less than 90 days. Temporary stay is defined as a stay that includes the month of admission and two months following admission. Consumers that remain in the institution following the two month allotment will be terminated from the HCBS program. The consumer can choose to reapply for services at a later date and will be reinstated if the consumer meets program eligibility requirements or placed on a waiting list if applicable.

**Describe how the amount of reserved capacity was determined:**

There is no data to support this projection of reserved capacity. If the amount of need exceeds reserve capacity, Kansas will submit an amendment to appropriately reflect the number unduplicated persons served.

**The capacity that the State reserves in each waiver year is specified in the following table:**

Waiver Year	Capacity Reserved
Year 1	2
Year 2	2
Year 3	2
Year 4	2
Year 5	2

## Appendix B: Participant Access and Eligibility

### B-3: Number of Individuals Served (3 of 4)

**d. Scheduled Phase-In or Phase-Out.** Within a waiver year, the state may make the number of participants who are served subject to a phase-in or phase-out schedule (*select one*):

**The waiver is not subject to a phase-in or a phase-out schedule.**

**The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

**e. Allocation of Waiver Capacity.**

*Select one:*

**Waiver capacity is allocated/managed on a statewide basis.**

**Waiver capacity is allocated to local/regional non-state entities.**

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

**f. Selection of Entrants to the Waiver.** Specify the policies that apply to the selection of individuals for entrance to the waiver:

Once the child has received a diagnosis of ASD they must also meet the level of care (functional) eligibility guidelines utilizing the state approved functional eligibility instrument. Entrance to the waiver is determined on a first come first serve basis. The date and time request for waiver services received at KDADS will be the determining factor. The number of eligible entrants into the program is limited to the number of waiver capacity allowed by funding.

The Autism Program Manager maintains a statewide "Proposed Recipient List" of those children who have a diagnosis of ASD, request Autism Waiver services, and have completed the necessary form indicating the name of the child, diagnosis, address, date of birth, phone number, and name of parent/guardian. The form can be faxed, mailed, or emailed to the Autism Program Manager where it will be date/time stamped. The date/timed stamped and/or faxed date/time will be the determining factor for the first come first serve policy. The "Proposed Waiver Recipient" list is being utilized to determine when a child will be offered services as HCBS/Autism slot becomes available. When a slot becomes available, the Autism Program Manager will send a letter to the family using the address on file notifying them of the available position. The family is given two weeks to respond to the letter informing the Program Manager if they would like to continue with the eligibility process. If the Program Manager does not receive a response they will reach out by phone confirming receipt of the letter and the parents choice. If the parent indicates they would like to pursue the Autism Waiver the Program Manager will notify the contracted functional assessor that an assessment is needed. Families are given a notice of action (NOA) if the child is found either functionally eligible or functionally ineligible. The NOA also contains appeal rights.

The Autism waiver consists of a continued interest list and does not have a waiting list. The State does not serve in excess of the allotted 65 at any point in time.

## Appendix B: Participant Access and Eligibility

### B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

## Appendix B: Participant Access and Eligibility

### B-4: Eligibility Groups Served in the Waiver

a. **1. State Classification.** The state is a (*select one*):

§1634 State

SSI Criteria State

209(b) State

**2. Miller Trust State.**

Indicate whether the state is a Miller Trust State (*select one*):

No

Yes

b. **Medicaid Eligibility Groups Served in the Waiver.** Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the state plan. The state applies all applicable federal financial participation limits under the plan. *Check all that apply:*

**Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)**

Low income families with children as provided in §1931 of the Act

**SSI recipients****Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121****Optional state supplement recipients****Optional categorically needy aged and/or disabled individuals who have income at:***Select one:***100% of the Federal poverty level (FPL)****% of FPL, which is lower than 100% of FPL.**Specify percentage: **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII) of the Act)****Working individuals with disabilities who buy into Medicaid (TWWIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)****Working individuals with disabilities who buy into Medicaid (TWWIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)****Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)****Medically needy in 209(b) States (42 CFR §435.330)****Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)****Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)***Specify:*

Parents and other caretaker relatives (42 CFR 435.110) Pregnant Women (42 CFR 435.116) Infants and Children under the age of 19 (42 CFR 435.118) Newborn Children (42 CFR 435.117)
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***Special home and community-based waiver group under 42 CFR §435.217*** Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed

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**No. The state does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. Appendix B-5 is not submitted.****Yes. The state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.***Select one and complete Appendix B-5.***All individuals in the special home and community-based waiver group under 42 CFR §435.217****Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217***Check each that applies:***A special income level equal to:***Select one:***300% of the SSI Federal Benefit Rate (FBR)****A percentage of FBR, which is lower than 300% (42 CFR §435.236)**



Specify percentage: **A dollar amount which is lower than 300%.**Specify dollar amount: **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)****Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)****Medically needy without spend down in 209(b) States (42 CFR §435.330)****Aged and disabled individuals who have income at:***Select one:***100% of FPL****% of FPL, which is lower than 100%.**Specify percentage amount: **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)***Specify:*

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (1 of 7)

*In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.*

- a. Use of Spousal Impoverishment Rules.** Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217:

*Note: For the period beginning January 1, 2014 and extending through September 30, 2019 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.*

**Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses *spousal* post-eligibility rules under §1924 of the Act.**

*Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).*

*Note: The following selections apply for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law) (select one).*

**Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

In the case of a participant with a community spouse, the state elects to (*select one*):

**Use spousal post-eligibility rules under §1924 of the Act.**

*(Complete Item B-5-b (SSI State) and Item B-5-d)*

**Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**

*(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)*

**Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The state uses regular post-eligibility rules for individuals with a community spouse.**

*(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)*

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (2 of 7)

*Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.*

#### **b. Regular Post-Eligibility Treatment of Income: SSI State.**

The state uses the post-eligibility rules at 42 CFR 435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

#### **i. Allowance for the needs of the waiver participant (select one):**

**The following standard included under the state plan**

*Select one:*

**SSI standard**

**Optional state supplement standard**

**Medically needy income standard**

**The special income level for institutionalized persons**

*(select one):*

**300% of the SSI Federal Benefit Rate (FBR)**

**A percentage of the FBR, which is less than 300%**

Specify the percentage:

**A dollar amount which is less than 300%.**

Specify dollar amount:

**A percentage of the Federal poverty level**

Specify percentage:

**Other standard included under the state Plan**

*Specify:*

**The following dollar amount**

Specify dollar amount:  If this amount changes, this item will be revised.

**The following formula is used to determine the needs allowance:**

*Specify:*

**Other***Specify:*

---

**ii. Allowance for the spouse only (select one):**

---

**Not Applicable**

**The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:**

*Specify:***Specify the amount of the allowance (select one):****SSI standard****Optional state supplement standard****Medically needy income standard****The following dollar amount:**

Specify dollar amount:  If this amount changes, this item will be revised.

**The amount is determined using the following formula:***Specify:*

---

**iii. Allowance for the family (select one):**

---

**Not Applicable (see instructions)****AFDC need standard****Medically needy income standard****The following dollar amount:**

Specify dollar amount:  The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the state's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

**The amount is determined using the following formula:***Specify:*

**Other***Specify:*



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**iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:**


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- a. Health insurance premiums, deductibles and co-insurance charges
- b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

**Not Applicable (see instructions)***Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*

**The state does not establish reasonable limits.**

**The state establishes the following reasonable limits**

*Specify:*



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**Appendix B: Participant Access and Eligibility**


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**B-5: Post-Eligibility Treatment of Income (3 of 7)**

*Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.*

**c. Regular Post-Eligibility Treatment of Income: 209(B) State.**


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**Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.**

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**Appendix B: Participant Access and Eligibility**


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**B-5: Post-Eligibility Treatment of Income (4 of 7)**

*Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.*

**d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules**

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

**i. Allowance for the personal needs of the waiver participant**
*(select one):*

**SSI standard**

**Optional state supplement standard**

**Medically needy income standard**

**The special income level for institutionalized persons**

**A percentage of the Federal poverty level**

Specify percentage:

**The following dollar amount:**

Specify dollar amount:  If this amount changes, this item will be revised

**The following formula is used to determine the needs allowance:**

*Specify formula:*

**Other**

*Specify:*

300% of SSI

- ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.**

Select one:

**Allowance is the same**

**Allowance is different.**

*Explanation of difference:*

- iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:**

- a. Health insurance premiums, deductibles and co-insurance charges
- b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

**Not Applicable (see instructions)***Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*

**The state does not establish reasonable limits.**

**The state uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

## Appendix B: Participant Access and Eligibility

*Note: The following selections apply for the five-year period beginning January 1, 2014.*

**e. Regular Post-Eligibility Treatment of Income: SSI State - 2014 through 2018.**

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**Answers provided in Appendix B-5-a indicate the selections in B-5-b also apply to B-5-e.**

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**Appendix B: Participant Access and Eligibility**

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**B-5: Post-Eligibility Treatment of Income (6 of 7)**

*Note: The following selections apply for the five-year period beginning January 1, 2014.*

**f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.**

---

**Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.**

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**Appendix B: Participant Access and Eligibility**

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**B-5: Post-Eligibility Treatment of Income (7 of 7)**

*Note: The following selections apply for the five-year period beginning January 1, 2014.*

**g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.**

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

---

**Answers provided in Appendix B-5-a indicate the selections in B-5-d also apply to B-5-g.**

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**Appendix B: Participant Access and Eligibility**

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**B-6: Evaluation/Reevaluation of Level of Care**

*As specified in 42 CFR §441.302(c), the state provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.*

**a. Reasonable Indication of Need for Services.** In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the state's policies concerning the reasonable indication of the need for services:

**i. Minimum number of services.**

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is:

**ii. Frequency of services.** The state requires (select one):

**The provision of waiver services at least monthly**

**Monthly monitoring of the individual when services are furnished on a less than monthly basis**

*If the state also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:*

**b. Responsibility for Performing Evaluations and Reevaluations.** Level of care evaluations and reevaluations are performed (*select one*):

**Directly by the Medicaid agency**

**By the operating agency specified in Appendix A**

**By a government agency under contract with the Medicaid agency.**

*Specify the entity:*

**Other**

*Specify:*

State contracted assessor contracting with Kansas is responsible for performing the evaluation and reevaluation for level of care determination as indicated in appendix A of this application.

**c. Qualifications of Individuals Performing Initial Evaluation:** Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

\*\*\*\*Must meet the qualifications specified by Pearson Assessments, as a level B user the assessor must meet one of the following qualifications:

"A master's degree in psychology, education, occupational therapy, social work, counseling, or in a field closely related to the intended use of the assessment, and formal training in the ethical administration, scoring, and interpretation of clinical assessments.

OR

Certification by or full active membership in a professional organization (such as ASHA, AOTA, AERA, ACA, AMA, CEC, AEA, AAA, EAA, NAEYC, NBCC) that requires training and experience in the relevant area of assessment.

OR

A degree or license to practice in the healthcare or allied healthcare field.

OR

Formal, supervised mental health, speech/language, occupational therapy, social work, counseling, and/or educational training specific to assessing children, or in infant and child development, and formal training in the ethical administration, scoring, and interpretation of clinical assessments."

-"User has a licensure to practice psychology independently, or User has completed a doctoral (or in some cases masters) degree program in one of the fields of study indicated for the test that included training (through coursework and supervised practical experience) in the administration and interpretation of clinical instruments. If neither of these qualifications are met, Users must provide proof that they have been granted the right to administer tests at this level in their jurisdiction".

\*Must be able to provide proof of professional liability insurance and automobile liability insurance coverage

\*Must complete KDADS approved training criteria, and

\*Must successfully pass Kansas Bureau of Investigation (KBI), Adult Protective Services (APS), Child Protective Services (CPS), Nurse Aid, and Motor Vehicle screen

**d. Level of Care Criteria.** Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the state's level of care instrument/tool. Specify

the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

A qualified Functional Eligibility Specialist conducts the level of care (functional eligibility) assessment of the child who is applying for waiver services within five (5) working days of the referral, unless a different timeframe is requested by the participant/family applying for services or their legal representative, if appropriate.

The Functional Eligibility Instrument (FEI) measures the personal and social skills of individuals from birth through adulthood. Because adaptive behavior refers to a participant's typical performance of the day-to-day activities required for personal and social sufficiency, these scales assess what a person actually does, rather than what he or she is able to do. The FEI assesses adaptive behavior in four domains: Communication, Daily Living Skills, Socialization, and Motor Skills. It also provides a composite score that summarizes the participant's performance across all four domains.

The child must have a total score or a score on any two elements of the Adaptive Areas (Communication, Daily Living skills, Socialization, and Motor skills) of two standard deviations below the mean of 100 (i.e., a score of 70 or below) in order to be eligible for the waiver.

Or

A total score or a score on any two elements of the Adaptive Areas (Communication, Daily Living Skills, Socialization and Motor skills) of one standard deviation below the mean of 100 (score of 71-85). This prompts the assessor to review the scores on the Maladaptive Behaviors (internal, external or total). If the child's v-scale score on any subdomain of the Maladaptive domain is between 21-24, the child is eligible for the Waiver.

The FEI is the Autism Waiver functional eligibility tool (LOC Determination) to be utilized to determine functional eligibility). The FEI is a measurement of personal and social skills from birth to adulthood. The FEI focuses on four adaptive domains and one maladaptive domain: within all of the domains there are sub-domains which allow for greater in-depth holistic approach in developing the plan of care. The following domains and sub-domains are: 1) communication, (subdomain-receptive, expressive, and written), 2) Daily Living Skills (sub-domain-personal, domestic, and community), 3) Socialization (subdomain- interpersonal relationships, play and leisure time, and coping skills), 4) Motor Skills (subdomain-fine and gross), 5) Maladaptive Behavior Index (subdomain-internalizing, externalizing, and other).

- e. Level of Care Instrument(s).** Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care (*select one*):

**The same instrument is used in determining the level of care for the waiver and for institutional care under the state Plan.**

**A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.



The Community Mental Health Center Screening Form is utilized to screen for a variety of intensive inpatient psychiatric services. The form includes information on presenting problem, risk factors, clinical impressions, and inpatient criteria. The form is not based on a standardized tool or assessment, but solely on the self-report of the participant or family and the clinical judgment of qualified mental health practitioner. The Community Mental Health Center Screening Form is the instrument used to assess the level of care for institutional care.

Although the Mental Health Screening Form and the FEI are comparable in addressing the areas (domains) of a child's life the State of Kansas choose the FEI because it goes into greater details in each domain which in turn allows the assessor to identify the specific problematic areas a child is experiencing. This is accomplished because the FEI is a standardized tool; it guides the assessor throughout all domains by having set specific questions. The assessor must rate each question according to the following rating scale;

- 2 (behavior is usually or habitually performed),
- 1 (sometimes or partly performed),
- 0 (never performed).

In addition there is a code N for instances when the child has never had the opportunity to perform the activity and or behavior. A code DK is when the caregiver does not know if the child performed the activity and or experienced the behavior. It also provides a composite score that summarized the individual's performance across the domains. Therefore, Kansas views the FEI to not only be comparable or equivalent to the Mental Health Screening Instrument but actually exceeds it by identifying and addressing the child's specific needs.

**f. Process for Level of Care Evaluation/Reevaluation:** Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

KDADS has contracted with one provider who will administer the FEI in order to determine the level of care (LOC) for functional eligibility and assist the child/family in obtaining eligibility for waiver services. The following criteria apply for waiver eligibility:

- 1) Age- at the time of entrance to the waiver a child must be between the ages of zero (0) through age five (5) years.
- 2) Diagnosis: Receive a diagnosis of Autism Spectrum Disorder (ASD) from a Licensed Medical Doctor or Ph.D. Psychologist using an approved Autism specific screening tool.
- 3) LOC determination: A functional assessment using the FEI must be completed and the child must meet the established scoring criteria in order to determine functional eligibility.
- 4) A child must be determined as likely to need inpatient psychiatric facility level of care in the absence of waiver services.
- 5) Family Choice form: Documentation to support Parents/Guardians choice of the waiver
- 6) Annual Reevaluation - The need for HCBS Autism Waiver services is re-evaluated (face to face) at a minimum on an annual basis but also any time the family feels it is appropriate, as needs change, and/or as goals are completed.

Notice of Action- When a child is found functionally eligible or ineligible during the initial evaluation or the annual re-evaluation the child/family will receive a Notice of Action advising them of the status of functional eligibility.

All functional eligibility documentation including the initial evaluation, the annual re-evaluation, freedom of choice and the notice of action are to be maintained in the child's case file.

**g. Reevaluation Schedule.** Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule (*select one*):

**Every three months**

**Every six months**

**Every twelve months**

**Other schedule***Specify the other schedule:*

- h. Qualifications of Individuals Who Perform Reevaluations.** Specify the qualifications of individuals who perform reevaluations (*select one*):

**The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**

**The qualifications are different.**

*Specify the qualifications:*

- i. Procedures to Ensure Timely Reevaluations.** Per 42 CFR §441.303(c)(4), specify the procedures that the state employs to ensure timely reevaluations of level of care (*specify*):

The contracted FES manages reevaluation lists and provides documentation to the State for each annual reevaluation that is completed.

The State currently contracts with KVC to do the initial evaluation and reevaluation of children on the Autism Waiver. KVC provides KDADS with a list of children that are up for reevaluation. KVC also provides KDADS with the evaluation times and if any changes need to occur, such as the family needing to reschedule. The Autism Program Manager verifies this list against the spread sheet kept at KDADS to ensure reevaluations are being done in a timely manner.

- j. Maintenance of Evaluation/Reevaluation Records.** Per 42 CFR §441.303(c)(3), the state assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

Records are maintained by the provider responsible for performing the initial eligibility determination and annual reevaluation (currently KVC). The contractor also supplies the state with a copy of initial eligibility determination and annual reevaluation information. The state assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §74.53. It will also be maintained in the State of Kansas Medicaid Management Information System(MMIS).

## Appendix B: Evaluation/Reevaluation of Level of Care

### Quality Improvement: Level of Care

*As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.*

**a. Methods for Discovery: Level of Care Assurance/Sub-assurances**

*The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.*

**i. Sub-Assurances:**

- a. **Sub-assurance:** *An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.*

### Performance Measures

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

### Performance Measure:

**Number and percent of waiver participants who were determined to meet Level of Care requirements prior to receiving HCBS services**  
 $N = \text{Number of waiver participants who were determined to meet Level of Care requirements prior to receiving HCBS services}$   
 $D = \text{Total number of enrolled waiver participants}$

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Operating Agency's data systems and Managed Care Organizations (MCOs) encounter data**

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <div>95%</div>
<b>Other</b> Specify: <div>Contracted assessors and Managed Care Organizations (MCOs)</div>	<b>Annually</b>	<b>Stratified</b> Describe Group: <div>Proportionate by MCO</div>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:

		<input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

- b. Sub-assurance:** *The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.*

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**

**Number and percent of waiver participants who receive their annual Level of Care evaluation within 12 months of the previous Level of Care determination N=Number of waiver participants who receive their annual Level of Care evaluation within 12 months of the previous Level of Care determination D=Number of waiver participants who received Level of Care redeterminations**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Operating agency's data systems: “Kansas Assessment Management Information (KAMIS) System or its related web applications”**

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <div>95%</div>
<b>Other</b> Specify: <div>Contracted assessors</div>	<b>Annually</b>	<b>Stratified</b> Describe Group: <div>Proportionate by MCO</div>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <div></div>
	<b>Other</b> Specify: <div></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> Contracted assessors participate in analysis of this measure's results as determined by the State operating agency </div>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <div style="border: 1px solid black; height: 30px; margin-top: 10px;"></div>

**c. Sub-assurance:** *The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.*

#### Performance Measures

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

#### Performance Measure:

**Number and percent of all Level of Care (LOC) determinations made by a qualified assessor**  
**N=Number of all Level of Care (LOC) determinations made by a qualified assessor**  
**D=Number of all Level of Care determinations**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Assessor and assessment records**

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
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<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
<b>Other</b> Specify: <div style="border: 1px solid black; padding: 2px; margin-top: 5px;">Contracted assessors</div>	<b>Annually</b>	<b>Stratified</b> Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <div style="border: 1px solid black; padding: 5px; margin-top: 5px;">Contracted assessors participate in analysis of this measure's results as determined by the State operating agency</div>	<b>Annually</b>

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

**Performance Measure:**

**Number and percent of waiver participants whose Level of Care (LOC) determinations used the state's approved screening tool**  
**N=Number of waiver participants whose Level of Care determinations used the approved screening tool**  
**D=Number of waiver participants who had a Level of Care determination**

**Data Source** (Select one):**Other**

If 'Other' is selected, specify:

**Record reviews**

<b>Responsible Party for data collection/generation</b> ( <i>check each that applies</i> ):	<b>Frequency of data collection/generation</b> ( <i>check each that applies</i> ):	<b>Sampling Approach</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <div style="border: 1px solid black; padding: 2px; width: 100px; margin-top: 5px;">95%</div>
<b>Other</b> Specify: <div style="border: 1px solid black; padding: 2px; width: 100px; margin-top: 5px;">Contracted assessors</div>	<b>Annually</b>	<b>Stratified</b> Describe Group: <div style="border: 1px solid black; padding: 2px; width: 100px; margin-top: 5px;">Proportionate by MCO</div>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>



	<b>Other</b> Specify: <div style="border: 1px solid black; height: 30px; width: 150px; margin-top: 10px;"></div>	
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**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <div style="border: 1px solid black; padding: 5px; margin-top: 10px;">Contracted assessors participate in analysis of this measure's results as determined by the State operating agency</div>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <div style="border: 1px solid black; height: 30px; width: 200px; margin-top: 10px;"></div>

**Performance Measure:**

Number and percent of all Level of Care (LOC) determinations made where the LOC criteria was accurately applied N=Number of all Level of Care (LOC) determinations made where the LOC criteria was accurately applied D=Number of all Level of Care determinations

**Data Source** (Select one):**Other**

If 'Other' is selected, specify:

**Record reviews**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>

<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <div>95%</div>
<b>Other</b> Specify: <div>Contracted assessors</div>	<b>Annually</b>	<b>Stratified</b> Describe Group: <div>Proportionate by MCO</div>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <div></div>
	<b>Other</b> Specify: <div></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <div>Contracted assessors participate in analysis of this measure's results as determined by the State operating agency</div>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b>

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
	Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

These performance measures will be included as part of the comprehensive KanCare State Quality Improvement Strategy, and assessed quarterly with remediation to follow as necessary. In addition, the performance of the contracted Functional Specialist will be monitored on an ongoing basis to ensure compliance with the contract requirements.

**b. Methods for Remediation/Fixing Individual Problems**

- i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

These measures and collection/reporting protocols, together with others that are part of the KanCare MCO contract, are included in a statewide comprehensive KanCare quality improvement strategy which is regularly reviewed and adjusted. That plan is contributed to and monitored through a state interagency monitoring team, which includes program managers, contract managers, fiscal staff and other relevant staff/resources from both the state Medicaid agency and the state operating agency.

State staff request, approve, and assure implementation of contractor corrective action planning and/or technical assistance to address non-compliance with performance standards as detected through on-site monitoring, survey results and other performance monitoring. These processes are monitored by both contract managers and other relevant state staff, depending upon the type of issue involved, and results tracked consistent with the statewide quality improvement strategy and the operating protocols of the interagency monitoring team.

**ii. Remediation Data Aggregation**

**Remediation-related Data Aggregation and Analysis (including trend identification)**

<b>Responsible Party</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <div style="border: 1px solid black; padding: 2px;">KanCare MCOs participate in analysis</div>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:

Responsible Party( <i>check each that applies</i> ):	Frequency of data aggregation and analysis ( <i>check each that applies</i> ):
	<div data-bbox="863 215 1337 293" style="border: 1px solid black; height: 35px; width: 100%;"></div>

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

**No**

**Yes**

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

## Appendix B: Participant Access and Eligibility

### B-7: Freedom of Choice

**Freedom of Choice.** As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:

- i. informed of any feasible alternatives under the waiver; and
- ii. given the choice of either institutional or home and community-based services.

**a. Procedures.** Specify the state's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Kansas continues to offer families a choice between an Inpatient psychiatric facility for individuals less than 21 years of age as provided in 42CFR 440.160 and Home Community Based Services (HCBS). Families shall be informed of any feasible alternative available under the waiver, and given the choice of either inpatient psychiatric facility or home and community -based services [42 CFR 441.302(d)]. Due to the age, numbers served and targeted population for this waiver, if a family should choose an Inpatient psychiatric facility rather than HCBS, Kansas, through the managed care delivery model, enters into a contract with an out of state provider to provide services for that child.

After the child is determined to be eligible for the HCBS/Autism waiver services, the child/family receives:

- 1) A copy of the completed form(s) used to document freedom of choice and to offer a fair hearing;
- 2) A description of the contracted functional assessors procedure(s) for informing eligible children (or their legal representatives) of the feasible alternatives available under the waiver;
- 3) A description of the State's procedures for allowing participants to choose either institutional or home and community-based services; and
- 4) A description of how the participant (or legal representative) is offered the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E.
- 5) Because of its importance, the chosen Managed Care Organization (MCO) is responsible for providing or explaining the freedom of choice form to the child/family.
- 6) The Freedom of Choice form is signed at the time the Level of Care assessment is completed.

- b. Maintenance of Forms.** Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

The Family Choice Document (freedom of choice) form, Rights and Responsibilities, and Request for a Fair Hearing is maintained in the child's case file at the individual provider/agency responsible for determining eligibility per K.A.R. 30-60-57. A child's/family members signature on the Family Choice Document indicates and ensures they have been informed of the options available.

## Appendix B: Participant Access and Eligibility

### B-8: Access to Services by Limited English Proficiency Persons

**Access to Services by Limited English Proficient Persons.** Specify the methods that the state uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

KDADS has taken steps to assist staff in communicating with their Limited English Proficient Persons, and to meet the provisions set out in the Department of Health and Human Services Policy Guidance of 2000 requiring agencies which receive federal funding to provide meaningful access to services by Limited English Proficient Persons. In order to comply with federal requirements that individuals receive equal access to services provided by KDADS and to determine the kinds of resources necessary to assist staff in ensuring meaningful communication with Limited English Proficient participants, states are required to capture language preference information. This information is captured in the demographic section of the Vineland instrument.

The State of Kansas defines prevalent non-English languages as languages spoken by a significant number of potential enrollees and enrollees. Potential enrollee and enrollee materials will be translated into the prevalent non-English languages.

Each contracted provider is required by Kansas regulation to make every reasonable effort to overcome any barrier that participants may have to receiving services, including any language or other communication barrier. This is achieved by having staff available to communicate with the participant in his/her spoken language, and/or access to a phone-based translation services so that someone is readily available to communicate orally with the participant in his/her spoken language. (K.A.R. 30-60-15).

Access to a phone-based translation system is under contract with KDADS and available statewide.

## Appendix C: Participant Services

### C-1: Summary of Services Covered (1 of 2)

- a. Waiver Services Summary.** List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:

Service Type	Service		
Statutory Service	Respite Care		
Other Service	Family Adjustment Counseling		
Other Service	Parent Support and Training (peer to peer) Provider		

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Statutory Service

**Service:**

Respite

**Alternate Service Title (if any):**

Respite Care

**HCBS Taxonomy:****Category 1:**

09 Caregiver Support

**Sub-Category 1:**

09011 respite, out-of-home

**Category 2:**

09 Caregiver Support

**Sub-Category 2:**

09012 respite, in-home

**Category 3:****Sub-Category 3:****Service Definition (Scope):****Category 4:****Sub-Category 4:**

Respite Care provides temporary direct care and supervision for the child. The primary purpose is relief to families/caregivers of a child with an autism spectrum disorder. The service is designed to help meet the needs of the primary caregiver as well as the identified child. Normal activities of daily living are considered content of the service when providing respite care, and include support in the home, after school, or at night.

Transportation to and from school/medical appointments/ or other community based activities, and/or any combination of the above is included in the rate paid to providers of this services.

Federal financial participation (FFP) is not claimed for the cost of room and board.

Respite care does not duplicate any other Medicaid State Plan Service or service otherwise available to recipient at no cost.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

1) Respite Care services are available to participants who have a family member who serves as the primary care giver who is not paid to provide any HCBS/ Autism service for the child.

2) Respite care may not be provided by a parent of the child.

3) Respite Care cannot be provided to an individual who is an inpatient of a hospital or State Mental Hospital when the inpatient facility is billing Medicaid, Medicare and/ or private insurance.

4) Respite Services are subject to prior approval.

5) Respite care is provided in planned or emergency segments and may include payment during the individuals sleep time

6) Respite has a soft limit to 168 hours per calendar year. Families may request additional hours of Respite care by contacting their MCO care coordinator.

**Service Delivery Method** (*check each that applies*):**Participant-directed as specified in Appendix E****Provider managed****Specify whether the service may be provided by** (*check each that applies*):**Legally Responsible Person****Relative****Legal Guardian****Provider Specifications:**

Provider Category	Provider Type Title
Agency	Community Service Provider, (CSP) and Community Mental Health Center, (CMHC)
Individual	Respite Care Provider

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Statutory Service****Service Name: Respite Care****Provider Category:**

Agency

**Provider Type:**

Community Service Provider, (CSP) and Community Mental Health Center, (CMHC)

**Provider Qualifications****License** (*specify*):

Community Service Provider will be licensed by KDADS,  
 Community Mental Health Center will be licensed under K.A.R. 30-60-1

**Certificate** (*specify*):**Other Standard** (*specify*):

Adherence to KDADS training and professional development requirements; maintenance of clear background as evidenced through background checks of; Kansas Bureau of Investigation (KBI), Adult Protective Services (APS), Child Protective Services (CPS), Nurse Aide Registry, and Motor Vehicle screen.

The motor vehicle screen can be waived for positions which DO NOT require driving as a function of the position.

Any provider found identified to have been substantiated for prohibited offenses as listed in KSA 39-970 & 65-5117 is not eligible for reimbursement of services under Medicaid funding.

High School Diploma or equivalent,

Eighteen years of age or older,

Must meet family's qualifications,

Must reside outside of child's home,

Completion of the state approved training curriculum, and

Medicaid Enrolled Provider

MCO contracted provider

#### **Verification of Provider Qualifications**

##### **Entity Responsible for Verification:**

Kansas Department of Health and Environment (KDHE), through the state fiscal agent; and KanCare MCOs.

##### **Frequency of Verification:**

Kansas provides monitoring and oversight of MCO's verification of HCBS-Autism provider qualifications. This oversight review is completed at least annually by KDADS and reported to the Medicaid Agency.

## **Appendix C: Participant Services**

### **C-1/C-3: Provider Specifications for Service**

**Service Type: Statutory Service**

**Service Name: Respite Care**

#### **Provider Category:**

Individual

#### **Provider Type:**

Respite Care Provider

#### **Provider Qualifications**

**License (specify):**

**Certificate (specify):**



**Other Standard** (*specify*):

Adherence to KDADS training and professional development requirements; maintenance of clear background as evidenced through background checks of; Kansas Bureau of Investigation (KBI), Adult Protective Services (APS), Child Protective Services (CPS), Nurse Aide Registry, and Motor Vehicle screen.

The motor vehicle screen can be waived for positions which DO NOT require driving as a function of the position.

Any provider found identified to have been substantiated for prohibited offenses as listed in KSA 39-970 & 65-5117 is not eligible for reimbursement of services under Medicaid funding.

High School Diploma or equivalent,

Eighteen years of age or older,

Must meet family's qualifications,

Must reside outside of child's home,

Completion of the state approved training curriculum, and

Medicaid Enrolled Provider

MCO contracted provider

**Verification of Provider Qualifications****Entity Responsible for Verification:**

Kansas Department of Health and Environment (KDHE), through the state fiscal agent; and KanCare MCOs.

**Frequency of Verification:**

Kansas provides monitoring and oversight of MCO's verification of HCBS-Autism provider qualifications. This oversight review is completed at least annually by KDADS and reported to the Medicaid Agency.

**Appendix C: Participant Services****C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

## Family Adjustment Counseling

**HCBS Taxonomy:****Category 1:**

10 Other Mental Health and Behavioral Services

**Sub-Category 1:**

10060 counseling

**Category 2:****Sub-Category 2:****Category 3:****Sub-Category 3:****Service Definition (Scope):****Category 4:****Sub-Category 4:**

Counseling can be provided to the family members of a child with an autism spectrum disorder in order to guide and help them cope with the child's illness and the related stress that accompanies the initial understanding of the diagnosis and the ongoing continuous, daily care required by the child with an autism spectrum disorder. Enabling the family to manage this stress improves the likelihood that the child with the disorder will continue to be cared for at home, thereby preventing premature and otherwise unnecessary institutionalization. Family Adjustment Counseling offers the family a mechanism for expressing emotions associated with the comprehension of the disorder and asking questions about the disorder in a safe and supporting environment. When acceptance of the disorder can be achieved the family is prepared to support the child on an ongoing basis. The service is provided by a Licensed Mental Health Professional (LMHP).

For the purposes of this service, "family" is defined as unpaid persons who live with or provide care to a person served on the waiver, and may include a parent, step parent, legal guardian, siblings, relatives, or grandparents. Services may be provided individually or in a group setting, are subject to prior approval, and must be intended to achieve the goals or objectives identified in the child's individualized plan of care.

Family Adjustment Counseling does not duplicate any other Medicaid State Plan Service or other services otherwise available to recipient at no cost. Family Adjustment Counseling provides the family the ability to meet with a counselor who is a Licensed Mental Health Professional to assist in coping with the child's illness and the related stress that accompanies the initial understanding of the diagnosis and the ongoing, continuous, and daily care required by the child with an ASD. This model allows the family to meet with a counselor without the child present.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

Family Adjustment Counseling is limited to 12 hours per calendar year.

Families may request more hours from their MCO if needed.

Services are subject to prior approval, and must be intended to achieve the goals or objectives identified in the child's individualized behavioral plan of care.

Group setting cannot consist of more than 3 families.

The group membership requirement for Family Adjustment Counseling is that members each have a family member with a diagnosis of ASD.

Families must agree to a group setting

Delivery of this service may occur via telemedicine, telehealth or other modes of video distance monitoring methods that adhere to all required HIPPA guidelines and meet the state standards for telemedicine delivery methods. This service delivery model is subject to state program manager approval. A request submitted for this exception must include, at a minimum, three (3) written statements from service providers in at least a 50 mile radius declining to provide services because the child/family resides in a location that is so remote or far away that the provider does not have staff to meet with the child on a continual and/or intermittent basis as needed.

**Service Delivery Method** (*check each that applies*):

**Participant-directed as specified in Appendix E**

**Provider managed**

**Specify whether the service may be provided by** (*check each that applies*):

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Community Mental Health Center
Individual	Family Adjustment Counseling Provider

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**

**Service Name: Family Adjustment Counseling**

**Provider Category:**

Agency

**Provider Type:**

Community Mental Health Center

**Provider Qualifications**

**License** (*specify*):

-Community Mental Health Center must operate and function within regulatory guidelines set forth in K.A.R. 30-60-1

**Certificate** (*specify*):

--

**Other Standard** (*specify*):

Adherence to KDADS training and professional development requirements; maintenance of clear background as evidenced through background checks of; Kansas Bureau of Investigation (KBI), Adult Protective Services (APS), Child Protective Services (CPS), Nurse Aide Registry, and Motor Vehicle screen.

The motor vehicle screen can be waived for positions which DO NOT require driving as a function of the position.

Any provider found identified to have been substantiated for prohibited offenses as listed in KSA 39-970 & 65-5117 is not eligible for reimbursement of services under Medicaid funding.

Medicaid Enrolled Provider

MCO contracted provider

**Verification of Provider Qualifications****Entity Responsible for Verification:**

Kansas Department of Health and Environment (KDHE), through the state fiscal agent; and KanCare MCOs.

**Frequency of Verification:**

Kansas provides monitoring and oversight of MCO's verification of HCBS-Autism provider qualifications. This oversight review is completed at least annually by KDADS and reported to the Medicaid Agency.

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service**

**Service Type: Other Service**

**Service Name: Family Adjustment Counseling**

**Provider Category:**

Individual

**Provider Type:**

Family Adjustment Counseling Provider

**Provider Qualifications****License** (*specify*):

a Licensed Mental Health Professional (LMHP) must hold a current license to practice in the state of Kansas by the Kansas Behavioral Sciences Regulatory Board, K.A.R. 28-5-564

**Certificate** (*specify*):

--

**Other Standard** (*specify*):

Adherence to KDADS training and professional development requirements; maintenance of clear background as evidenced through background checks of; Kansas Bureau of Investigation (KBI), Adult Protective Services (APS), Child Protective Services (CPS), Nurse Aide Registry, and Motor Vehicle screen.

The motor vehicle screen can be waived for positions which DO NOT require driving as a function of the position.

Any provider found identified to have been substantiated for prohibited offenses as listed in KSA 39-970 & 65-5117 is not eligible for reimbursement of services under Medicaid funding.

Medicaid Enrolled Provider

MCO contracted provider

### Verification of Provider Qualifications

#### Entity Responsible for Verification:

Kansas Department of Health and Environment (KDHE), through the state fiscal agent; and KanCare MCOs.

#### Frequency of Verification:

Kansas provides monitoring and oversight of MCO's verification of HCBS-Autism provider qualifications. This oversight review is completed at least annually by KDADS and reported to the Medicaid Agency.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

#### Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

#### Service Title:

Parent Support and Training (peer to peer) Provider

#### HCBS Taxonomy:

##### Category 1:

09 Caregiver Support

##### Sub-Category 1:

09020 caregiver counseling and/or training

##### Category 2:

##### Sub-Category 2:

##### Category 3:

##### Sub-Category 3:

☐

**Service Definition** (*Scope*):

**Category 4:**

**Sub-Category 4:**

☐

Parent Support and Training is designed to provide the training and support necessary to ensure engagement and active participation of the family in the treatment process and with the ongoing implementation and reinforcement of skills learned throughout the treatment process. Support and Training is provided to family members to increase their ability to provide a safe and supportive environment in the home and community for the child. This involves assisting the family with the acquisition of knowledge and skills necessary to understand and address the specific needs of the child in relation to their autism spectrum disorder and treatment; and development and enhancement of the family's specific problem-solving skills, coping mechanisms, and strategies for the child's symptom/behavior management.

For the purposes of this service, "family" is defined as persons who live with or provide care to a child served on the waiver, and may include a parent, step parent, legal guardian, siblings, relatives, grandparents, or foster parents. Services may be provided individually or in a group setting, are subject to prior approval, and must be intended to achieve the goals or objectives identified in the child's individualized plan of care.

1. Support, coaching and training provided to family members to increase their ability to provide a safe and supportive environment in the home and community for the member.
2. This involves helping the families identify and use healthy coping strategies to decrease caregiver strain, improve relationships with family, peers and community members and increase social supports;
3. Assist the family in the acquisition of knowledge and skills necessary to understand and address the specific needs of the participant in relation to their mental illness and treatment;
4. Development and enhancement of the families' specific problem-solving skills, coping mechanisms, and strategies for the participant's symptom/behavior management;
5. Assist the family in understanding various requirements of the waiver or grant process, such as the crisis plan and plan of care process;
6. Educational information and understanding on the participant's medications or diagnoses; interpreting choice offered by service providers; and assisting with understanding policies, procedures and regulations that impact the participant with mental illness while living in the community; provide information on supportive resources in the community;
7. Service must be intended to achieve the goals and/or objectives identified in the participant's individualized plan of care.

Parent Support and Training does not duplicate any other Medicaid State Plan Service or other services otherwise available to recipient at no cost.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

Parent Support and Training is limited to 30 hours per calendar year.

Families may request more hours from their MCO if needed.”

Services are subject to prior approval, and must be intended to achieve the goals or objectives identified in the child’s individualized behavioral plan of care.

Group settings cannot consist of more than 3 families.

The group membership requirement for Parent Support is that members each have a family member with a diagnosis of ASD.

Families must agree to a group setting

Delivery of this service may occur via telemedicine, telehealth or other modes of video distance monitoring methods that adhere to all required HIPPA guidelines and meet the state standards for telemedicine delivery methods. This service delivery model is subject to state program manager approval. A request submitted for this exception must include, at a minimum, three (3) written statements from service providers in at least a 50 mile radius declining to provide services because the child/family resides in a location that is so remote or far away that the provider does not have staff to meet with the child on a continual and/or intermittent basis as needed.

**Service Delivery Method** (*check each that applies*):

**Participant-directed as specified in Appendix E**

**Provider managed**

**Specify whether the service may be provided by** (*check each that applies*):

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Parent Support Provider
Agency	Community Service Providers, (CSP) and Community Mental Health Centers (CMHC)

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**

**Service Name: Parent Support and Training (peer to peer) Provider**

**Provider Category:**

Individual

**Provider Type:**

Parent Support Provider

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

**Other Standard** (*specify*):

Adherence to KDADS training and professional development requirements; maintenance of clear background as evidenced through background checks of; Kansas Bureau of Investigation (KBI), Adult Protective Services (APS), Child Protective Services (CPS), Nurse Aide Registry, and Motor Vehicle screen.

The motor vehicle screen can be waived for positions which DO NOT require driving as a function of the position.

Any provider found identified to have been substantiated for prohibited offenses as listed in KSA 39-970 & 65-5117 is not eligible for reimbursement of services under Medicaid funding.

The motor vehicle screen can be waived for positions which DO NOT require driving as a function of the position.

\*High School Diploma or equivalent

\*Twenty-one years of age or older

\*Completion of parent support training or other approved training curriculum.

\*Must have three years of direct care experience with a child with an autism spectrum disorder, Or be the parent of a child with an autism spectrum disorder

\*Medicaid Enrolled Provider

\* MCO contracted provider

**Verification of Provider Qualifications****Entity Responsible for Verification:**

Kansas Department of Health and Environment (KDHE), through the state fiscal agent; and KanCare MCOs.

**Frequency of Verification:**

Kansas provides monitoring and oversight of MCO's verification of HCBS-Autism provider qualifications. This oversight review is completed at least annually by KDADS and reported to the Medicaid Agency.

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Parent Support and Training (peer to peer) Provider****Provider Category:**

Agency

**Provider Type:**

Community Service Providers, (CSP) and Community Mental Health Centers (CMHC)

**Provider Qualifications****License** (*specify*):



Community Service Providers are licensed by KDADS  
Community Mental Health Center will be licensed under K.A.R. 30-60-1

All licensed agencies that are on file with the Secretary of State's office that are or can become Medicaid enrolled, and employ individuals that meet the qualifications of a parent support and training provider. The types of licensed agencies that can enroll in Medicaid to provide HCBS services are listed here: <https://www.kmap-state-ks.us/Documents/Content/Checklists/HCBS.PDF>.

**Certificate** (*specify*):

**Other Standard** (*specify*):

Adherence to KDADS training and professional development requirements; maintenance of clear background as evidenced through background checks of; Kansas Bureau of Investigation (KBI), Adult Protective Services (APS), Child Protective Services (CPS), Nurse Aide Registry, and Motor Vehicle screen.

The motor vehicle screen can be waived for positions which DO NOT require driving as a function of the position.

Any provider found identified to have been substantiated for prohibited offenses as listed in KSA 39-970 & 65-5117 is not eligible for reimbursement of services under Medicaid funding.

\*High School Diploma or equivalent

\*Twenty-one years of age or older

\*Completion of parent support training or other approved training curriculum.

\*Must have three years of direct care experience with a child with an autism spectrum disorder, Or be the parent of a child with an autism spectrum disorder.

\*Medicaid Enrolled provider and MCO contracted provider

#### **Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Kansas Department of Health and Environment (KDHE), through the state fiscal agent; and KanCare MCOs.

**Frequency of Verification:**

Kansas provides monitoring and oversight of MCO's verification of HCBS-Autism provider qualifications. This oversight review is completed at least annually by KDADS and reported to the Medicaid Agency.

## **Appendix C: Participant Services**

### **C-1: Summary of Services Covered (2 of 2)**

**b. Provision of Case Management Services to Waiver Participants.** Indicate how case management is furnished to waiver participants (*select one*):

**Not applicable** - Case management is not furnished as a distinct activity to waiver participants.

**Applicable** - Case management is furnished as a distinct activity to waiver participants.

*Check each that applies:*

**As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*

**As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*

**As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*

**As an administrative activity.** *Complete item C-1-c.*

**As a primary care case management system service under a concurrent managed care authority.** *Complete item C-1-c.*

**c. Delivery of Case Management Services.** Specify the entity or entities that conduct case management functions on behalf of waiver participants:

## Appendix C: Participant Services

### C-2: General Service Specifications (1 of 3)

**a. Criminal History and/or Background Investigations.** Specify the state's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

**No. Criminal history and/or background investigations are not required.**

**Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

The contactor / sub contactor and /or provider must complete a Kansas Bureau of Investigation (KBI), Adult Protective Services (APS), Child Protective Services (CPS), Nurse Aide Registry, and motor vehicle screen upon the hiring of the following providers of services:

- Eligibility Determination (Functional Eligibility Specialist)
- Respite Care Provider
- Parent Support Specialist Provider
- Family Adjustment Counseling Provider

The contactor / sub contactor and /or provider must provide evidence that required standards have been met at the time of renewing their license. This standard can be reviewed by KDADS regional field staff at the time of their reviews and sooner if a potential problem is identified. At any time deemed appropriate by KDADS, a certification may be formally resurveyed by KDADS to determine whether the licensee continues to be in compliance with the requirements, per K.A.R. 30-60-6

A single provider must provide the above documentation along with qualifications to the MCO and receive prior authorization before the delivery of services.

The completion of all required background checks and screenings are the responsibility of the potential waiver provider. All background checks/screens must be completed and submitted with provider enrollment applications. If a provider is identified to have an offense on the Prohibited Offenses list, there is no exception. Any potential service provider found to be convicted of a Prohibited Offense will not be enrolled or credentialed as a waiver provider.

**b. Abuse Registry Screening.** Specify whether the state requires the screening of individuals who provide waiver services through a state-maintained abuse registry (select one):

**No. The state does not conduct abuse registry screening.**

**Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The contractor / sub contactor and /or provider must check all individuals against the Kansas Department for Children and Families (DCF) child abuse, adult abuse and nurses aid registries. DCF Children and Adults Services maintain the registries for all confirmed perpetrators.

- Functional Eligibility Determination (Eligibility Specialist)
- Respite Care Provider
- Parent Support Specialist Provider
- Family Adjustment Counseling Provider

The contractor / sub contactors and /or providers must provide evidence that required standards have been met at the time of renewing their license. This standard can be reviewed by KDADS regional field staff at the time of their reviews and sooner if a potential problem is identified. At any time deemed appropriate by KDADS, a certification may be formally resurveyed by KDADS to determine whether the licensee continues to be in compliance with the requirements, per K.A.R. 30-60-6

All background checks/screens are the responsibility of the potential waiver provider. All results must be submitted with all other required documentation at the time the application is submitted. There are no exceptions for those who have been identified with an offense listed on the Prohibited Offenses list. Any potential service provider found to be convicted of a Prohibited Offense will not be enrolled or credentialed as a waiver provider.

## Appendix C: Participant Services

### C-2: General Service Specifications (2 of 3)

**c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:***

**No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**

**Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

## Appendix C: Participant Services

### C-2: General Service Specifications (3 of 3)

**d. Provision of Personal Care or Similar Services by Legally Responsible Individuals.** A legally responsible individual is any person who has a duty under state law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the state, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one:*

**No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.**

**Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) state policies that specify the circumstances when payment may be authorized for the provision of **extraordinary care** by a legally responsible individual and how the state ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

**Self-directed**

**Agency-operated**

**e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians.** Specify state policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one:*

**The state does not make payment to relatives/legal guardians for furnishing waiver services.**

**The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

**Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

**Other policy.**

Specify:

**f. Open Enrollment of Providers.** Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

Participants of HCBS-Autism waiver services have the right to choose who provides their services, within established guidelines regarding provider qualifications. Any qualified provider of those services may enroll through the Medicaid agency, Kansas Department of Health and Environment, (KDHE), for the Kansas Medical Assistance Program; and also must contract with, and meet the contracting terms of, the KanCare MCOs.

In addition to broad scale information and outreach by the state and the KanCare MCOs for all Medicaid providers, the providers that support HCBS waiver members have received additional outreach, information, transition planning and education regarding the KanCare program, to ensure an effective and smooth transition. In addition to the broader KanCare provider outreach (including educational tours and weekly stakeholder update calls), the providers that support HCBS waiver members have had focused discussions with state staff and MCO staff about operationalizing the KanCare program; about transition planning (and specific flexibility to support this) for the shift of targeted case management into MCO care management; and about member support in selecting their KanCare plan. The requirements, procedures and timeframes to quality have been clearly communicated via state and MCO information development and outreach as described above, and also via standardized credentialing applications and state-approved contracts which MCOs offered to each existing provider; and related information, including provider manuals has been made available via state and MCO websites.

All providers submit the required application, background check/screening, and required program specific documentation to the Kansas Medical Assistance Program (KMAP) at the time of enrollment. All applications are reviewed and processed in the order that they are received, usually within forty-five (45) days of application submission date provided a complete application is received.

## Appendix C: Participant Services

### Quality Improvement: Qualified Providers

*As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.*

#### **a. Methods for Discovery: Qualified Providers**

*The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.*

##### **i. Sub-Assurances:**

- a. Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.**

### Performance Measures

*For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

### Performance Measure:

**Number and percent of enrolled licensed/certified waiver providers that continue to meet licensure requirements, certification requirements, and other waiver standards**

**N=Number of enrolled licensed/certified waiver providers that continue to meet licensure requirements, certification requirements, and other waiver standards**

**D=Number of enrolled licensed/certified waiver providers**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Managed Care Organization (MCO) reports and record reviews**

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <div>95%</div>
<b>Other</b> Specify: <div>KanCare Managed Care Organizations (MCOs)</div>	<b>Annually</b>	<b>Stratified</b> Describe Group: <div>Proportionate by MCO</div>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:

		<input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**Number/percent of new licensed/certified waiver provider applicants that initially met licensure requirements, certification requirements, and other waiver standards prior to furnishing waiver services**  
 $N = \text{Number of new licensed/certified waiver provider applicants that initially met licensure requirements, etc. prior to furnishing waiver services}$   
 $D = \text{Number of all new licensed/certified providers}$

**Data Source** (Select one):**Other**

If 'Other' is selected, specify:

**KanCare Managed Care Organization (MCO) reports and record reviews**

<b>Responsible Party for data</b>	<b>Frequency of data collection/generation</b>	<b>Sampling Approach</b> <i>(check each that applies):</i>
-----------------------------------	--	--

<b>collection/generation</b> (check each that applies):	(check each that applies):	
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <div>95%</div>
<b>Other</b> Specify: <div>KanCare Managed Care Organizations (MCOs)</div>	<b>Annually</b>	<b>Stratified</b> Describe Group: <div>Proportionate by MCO</div>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <div></div>
	<b>Other</b> Specify: <div></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:	<b>Annually</b>



<b>Responsible Party for data aggregation and analysis</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency	
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

**b. Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.**

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

**Performance Measure:**

**Number and percent of enrolled non-licensed/non-certified waiver providers that continue to meet waiver requirements**  
 $N = \text{Number and percent of enrolled non-licensed/non-certified waiver providers that continue to meet waiver requirements}$   
 $D = \text{Number of enrolled non-licensed/non-certified providers}$

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Managed Care Organization (MCO) reports and record reviews**

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval =

		95%
<b>Other</b> Specify:  <div>KanCare Manged Care Organizations (MCOs)</div>	Annually	<b>Stratified</b> Describe Group:  <div>Proportionate by MCo</div>
	Continuously and Ongoing	<b>Other</b> Specify:  <div></div>
	<b>Other</b> Specify:  <div></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
<b>Other</b> Specify:  <div>KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency</div>	Annually
	Continuously and Ongoing
	<b>Other</b> Specify:  <div></div>

**Performance Measure:**

**Number and percent of new non-licensed/non-certified waiver provider applicants that have met the initial waiver requirements prior to furnishing waiver services**

**N=Number of new non-licensed/non-certified waiver provider applicants that have met the initial waiver requirements prior to furnishing wavier services D=Number of all new non-licensed/non-certified providers**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Managed Care Organization (MCO) reports and record reviews**

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <div>95%</div>
<b>Other</b> Specify: <div>KanCare Managed Care Organizations (MCOs)</div>	<b>Annually</b>	<b>Stratified</b> Describe Group: <div>Proportionate by MCO</div>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <div></div>
	<b>Other</b> Specify: <div></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:  <div style="border: 1px solid black; padding: 5px; width: fit-content;"> KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency </div>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:  <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

**c. Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.**

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

**Performance Measure:**

**Number and percent of active providers that meet training requirements** N=Number of providers that meet training requirements D=Number of active providers

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Managed Care Organization (MCO) reports and record reviews**

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>

<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <div>95%</div>
<b>Other</b> Specify: <div>KanCare Managed Care Organizations (MCOs)</div>	<b>Annually</b>	<b>Stratified</b> Describe Group: <div>Proportionate by MCO</div>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <div></div>
	<b>Other</b> Specify: <div></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <div>KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency</div>	<b>Annually</b>
	<b>Continuously and Ongoing</b>

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
	<b>Other</b> Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

These measures and collection/reporting protocols, together with others that are part of the KanCare MCO contract, are included in a statewide comprehensive KanCare quality improvement strategy which is regularly reviewed and adjusted. That plan is contributed to and monitored through a state interagency monitoring team, which includes program managers, fiscal staff and other relevant staff/resources from both the state Medicaid agency and the state operating agency.

KanCare MCOs are required to complete ongoing monitoring to ensure that their contracted providers meet all MCO credentialing and State Medicaid enrollments standards. The State completes MCO record reviews at least annually to ensure that all providers meet MCO credentialing and State enrollment standards.

The State completes record reviews with the MCOs to ensure that all MCO credentialed waiver providers meet the state Medicaid enrollment requirements. The state currently requires all Medicaid enrolled/MCO contracted providers to complete state approved training modules prior to delivering services. In the event that the training is not accessible at the time of enrollment providers are required to complete the state approved training modules within six (6) months of becoming an enrolled Medicaid approved provider. If the required training is not completed Medicaid enrollment/MCO contract is terminated.

**b. Methods for Remediation/Fixing Individual Problems**

- i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

State staff request, approve, and assure implementation of contractor corrective action planning and/or technical assistance to address non-compliance with performance standards as detected through on-site monitoring, MCO compliance monitoring, survey results and other performance monitoring. These processes are monitored by both contract managers and other relevant state staff, depending upon the type of issue involved, and results tracked consistent with the statewide quality improvement strategy and the operating protocols of the interagency monitoring team.

Data analysis is completed and remediated for any assurance or sub-assurance less than 100%. KDADS staff will notify the MCO of areas below 100% with details of each finding. KDADS staff will notify the MCO if a any findings are below 87%, those that fall below 87% are required to also include a quality improvement project. The MCO will be required to respond to the notification for remediation within 15 business days detailing their plan for correction. The plan will be reviewed by KDADS staff for approval of the plan. Should the plan not be approved, the provider will be notified and asked to resubmit an acceptable plan of correction. Once the remediation plan is approved, with a timeline for compliance, KDADS staff will continue to monitor through Quality Reviews to ensure compliance.

Any abuse, neglect or exploitation issue will be immediately reported to the designated state reporting agency. Any substantiated case of ANE will require remediation. The remediation plan must address how health and safety needs have been addressed including immediate corrective action and ongoing plan to prevent ANE.

Findings or concerns on a specific case identified through the review by Quality Management System (QMS) will be entered in Quality Review Tracker (QRT). Once entered, the QRT system will send an alert to the Assessor and/or MCO, and copy to the applicable Program Manager.

## ii. Remediation Data Aggregation

### Remediation-related Data Aggregation and Analysis (including trend identification)

<b>Responsible Party</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <div>KanCare Managed Care Organizations (MCOs)</div>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <div></div>

## c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

**No**

**Yes**

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

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## Appendix C: Participant Services

### C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

## Appendix C: Participant Services

### C-4: Additional Limits on Amount of Waiver Services

**a. Additional Limits on Amount of Waiver Services.** Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

**Not applicable-** The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

**Applicable -** The state imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

**Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.

*Furnish the information specified above.*

--

**Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.

*Furnish the information specified above.*

--

**Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.

*Furnish the information specified above.*

--

**Other Type of Limit.** The state employs another type of limit.

*Describe the limit and furnish the information specified above.*



The purpose of the Kansas Autism Waiver is to provide eligible Kansans the option to receive parental support in their home and community in a cost-efficient manner. Therefore, based on the type and scope of services, the Autism Waiver services is limited to three years unless the family requests a one (1) time one (1) year extension and is approved by the review team.

The three year limit applies to all services offered under this program. Autism waiver service limits has not changed since beginning of original or amended waiver. Waiver limits were designed based on research available at the time of program inception, stakeholder input and available funding for overall program administration.

Participants are provided information about the program at the time of initial program eligibility determination and notified of limitations by the MCO at the first assessment. Following level of care determination, the MCO are responsible for informing the participant of the program and service limitations. Program and specific service limitations are provided in the manuals and made available to the public on KDADS, KDHE, KanCare MCO and Kansas Medical Assistance Program (KMAP) websites.

The MCO may adjust the limitation based on the waiver participant's health/welfare needs or other factors documented in the participants Plan of Care. Both, the State and the MCOs, have appeal processes in place to ensure that waiver participants may appeal adverse actions. Details on the appeals/grievances processes are captured in Appendix F of the waiver.

## Appendix C: Participant Services

### C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

*Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.*

The State submitted a proposed Statewide Transition Plan pending CMS approval. see Main section, attachment #2

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (1 of 8)

#### State Participant-Centered Service Plan Title:

Plan of Care (POC)

- a. Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals (*select each that applies*):

**Registered nurse, licensed to practice in the state**

**Licensed practical or vocational nurse, acting within the scope of practice under state law**

**Licensed physician (M.D. or D.O)**

**Case Manager** (qualifications specified in Appendix C-1/C-3)

**Case Manager** (qualifications not specified in Appendix C-1/C-3).

*Specify qualifications:*

**Social Worker***Specify qualifications:***Other***Specify the individuals and their qualifications:*

Kansas has contracted with three managed care organizations, to provide overall management of these services as one part of the comprehensive KanCare program. The MCOs are responsible for plan of care development, and use their internal staff to provide that service. Kansas requires that conflict of interest be mitigated, and recognizes that the primary way in which that mitigation has been achieved is by separating from service providers the plan of care development, and making that an MCO function. (In addition, conflict has been mitigated by Kansas separating the level of care determination from any service delivery or plan of care development.) Some of the additional safeguards are in place to ensure that there is no conflict of interest in this function include the operational strategies for each MCO that are described in detail at Section D.1.d of this appendix.

Regarding Amerigroup: Service plans for Amerigroup members in waivers are developed by Service Coordinators who must have at least two years of experience working with individuals with chronic illness, comorbidities, and/or disabilities in a Service Coordinator, Case Management, Advocate or similar role. Preferred qualifications include experience in home health, health care, discharge planning, and behavioral health, collaborating with nursing facilities, community resources, and/or other home and community-based agencies. Experience working with Medicare, Medicaid and managed care programs is also preferred.

While a Master's degree is preferred, education/experience for Service Coordinators must include one of the following

- Bachelor's degree from an accredited college or university in Nursing, Social Work, Counseling, Special Education, Sociology, Psychology, Gerontology, or a closely related field, or State Waiver;
- Bachelor's Degree in an unrelated field and at least two years of geriatric experience; or
- In lieu of a bachelor's degree, six years of case management experience

Regarding Sunflower: Sunflower employs an Integrated Care Team approach for Service Plan Development. Teams conducting care coordination/care management are generally comprised of multidisciplinary clinical and nonclinical staff. This integrated approach allows non-medical personnel to perform non-clinical based service coordination and clerical functions, and permits the licensed professional staff to focus on the more complex and clinically based service coordination needs. Care Managers have primary responsibility for ensuring service plan development. Care managers are Registered Nurses and Master's level Behavioral Health clinicians with care management experience and, as applicable to the position, expertise including adult and pediatric medical, maternity and behavioral health/psychiatric care. Each Member receiving Care Management is assigned a lead Care Manager who oversees the Member's care. This includes, but is not limited to, participation in inpatient rounds with concurrent review nurses to assist with discharge and transitional care planning, and coordination with the Member's treating providers. Care Managers perform assessments, work with Members/caregivers to develop care plans, and provide educational resources and follow up in conjunction with the Integrated Care Team.

Regarding United: Service plans are developed by licensed nurses or licensed social workers.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (2 of 8)

#### b. Service Plan Development Safeguards. *Select one:*

**Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**

**Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (3 of 8)

- c. Supporting the Participant in Service Plan Development.** Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

According to K.A.R. 30-5-305 qualified staff and assessment providers shall conduct an assessment prior to the implementation of any HCBS services.

When the Functional Eligibility Specialist has determined a child likely to require the level of care provided in inpatient psychiatric facility for individuals under 21 years of age, the child/family or his/her legal representative will be (1) informed of any feasible alternative available under the waiver, and (2) given the choice of either institutional or home and community based services [42 CFR 441.302 (d), and permitted to choose between them.

Child/family has access to the following:

- A copy of the forms(s) used to document freedom of choice and to offer a fair hearing
- The HCBS/Autism Waiver Participant Rights and Responsibilities which, among other Rights and Responsibilities, lists the right to services which are provided to persons in their category of eligibility in accordance with the Medicaid State Plan, based on the availability of services and fiscal limitations.

b. Once the child/family has received the above mention information and would like to receive HCBS/Autism waiver services the child/family is then given a provider list in which the family chooses their provider(s). The child/family, unless a guardian is in place, have the right to determine who is included in the process, and which service providers to use.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (4 of 8)

- d. Service Plan Development Process.** In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Each participant found eligible for Autism waiver services can choose to receive services through the waiver program. The MCO is responsible for providing service options through the Autism waiver and the participant/parent or legal guardian choice of service options must be indicated on the Participant Choice form or on the Plan of Care (POC). This information is revisited by the MCO during the plan development process and specific services are identified that will best meet the participant's needs. During the POC development, the MCO conducts a needs assessment. Once this assessment is complete the MCO develops the POC for the participant that identifies the necessary services to meet the needs of the participant.

Participants and parents/legal guardians are informed of service options available through the waiver program by the MCO during the process of POC development. The participant's parent or legal guardian will indicate his/her choice to receive home and community based services on the Participant Choice Form. This information is revisited by the MCO during the plan development process and specific services are identified that will best meet the participant's needs.

The POC is developed during a face-to-face meeting with the participant, guardian, the MCO and any selected representatives that the participant's guardian chooses to be involved. With the participant's parent or legal guardian approval, family members or other individuals designated by the participant are encouraged to participate, to the greatest extent possible, in the development of and implementation of the POC. If the participant has a court appointed guardian/conservator or an activate durable power of attorney (DPOA) for health care decisions, the guardian/conservator or holder of the activated DPOA for health care decisions must be included and all necessary signatures documented on the POC. The location of the meeting is normally in the participant's home but arrangements can be made for another location if the participant or parent/legal guardian desires. Date and time is always coordinated based on the convenience of the participant and the participant's representative, if applicable.

The MCO assigns the participant with a care coordinator within fourteen (14) business days of financial eligibility approval. This timeframe must also include the MCO informing the participant and parent/legal guardian of all available service options and providers for whom the participant can access. The initial POC must be developed within seven (7) working days once a care coordinator has been identified. The State does not utilize interim service plans with this waiver. The development of the POC is finalized upon the guardian's review and signed authorization. A copy of the POC developed during the face-to-face meeting is provided to the participant and parent/legal guardian at the time of the meeting. The participant's guardian must sign an acknowledgement that the MCO has informed him/her of all service options and available providers of those services. Services provided are based upon the needs of the participant identified through the needs assessment and clearly documented on the participant's POC. The in-person health plan assessment and POC must be completed to allow the participant to begin receiving services within thirty (30) working days of financial eligibility determination.

Participants and parent/legal guardian are given free choice to select a qualified provider of each service included in his/her written POC. The MCO provides a list of providers from which the participant and parent/legal guardian can choose for services. The MCO assists the participant and parent/legal guardian with accessing information and supports from the participant's chosen provider.

The participant's desired outcomes and preferences are discussed when determining the services to be included in the POC. The participant and parent/legal guardian is involved in the development of the needs assessment regarding specific activities of daily living (ADLs) and instrumental activities of daily living (IADLs) associated with identified care needs and preferences.

A participant's POC is developed based on the information gathered from the following:

- Functional Eligibility Assessment
- Health Assessment

The State of Kansas ensures that the consumer's settings meet the requirements for compliance with the HCBS Final Setting Rule, including integration in the greater community.

The MCO is responsible for assuring the following elements are included in the person-centered plan:

- Reflect the setting in which the individual resides is chosen by the individual
- Includes the individual's strengths and preferences
- Be understandable to the individual receiving services and supports and the individuals important in supporting him/her

- Prevent the provision of unnecessary or inappropriate services and supports
- Document the positive interventions and supports including less intrusive methods
- Ongoing data measuring the effectiveness of modifications
- Assurance that interventions and supports will not cause harm.

The participant's POC takes into account information gathered from the Functional Eligibility Instrument and needs assessment, which identify potential risk factors. The POC documents the types of services to be furnished, the amount, frequency, and duration of each service, and the type of provider to furnish each service (including informal services and providers).

The MCO care coordinator must have a face-to-face meeting with the participant and guardian, and any selected representatives at least every six (6) months or on an as needed basis when updates must be made to update goals or needs in the participant's POC. During this face-to-face meeting, the POC is reviewed and updated in accordance with the participant's current needs. Any change to service needs requires a new POC be completed. A participant requesting a change of provider must inform MCO and allow thirty (30) days for the transition unless extenuating circumstance (i.e. ANE). The MCO must ensure a transitioning provider is identified before services with the current provider end, to ensure continuity of care. The POC is updated in accordance with the participant's change in provider. For each service change the POC must be signed or resigned by both the MCO and the participant or parent/legal guardian.

A copy of the POC developed during the face-to-face meeting is provided to the participant or participant-selected representative at the time of the meeting. The MCO shall send the POC and Notice of Action (NOA) to all involved parties, i.e., the participant, providers, activated DPOA, guardian, and conservator.

The MCO completes the appropriate forms indicating service tasks necessary to enable the participant to live safely in the most integrated environment possible. The MCO shall inform the provider, participant, guardian/DPOA (if applicable), family member, advocate, or other person acting on behalf of the participant of the rate of services and discuss the hours of care to be delivered to the participant.

The MCO shall record all pertinent information received verbally or in writing from the participant, staff or collateral contacts in the case log. The MCO shall send the POC, the identified service tasks to be performed indicated from the POC, and Notice of Action (NOA) to all involved parties, i.e., the participant, providers, activated durable power of attorney, guardian, and conservator.

The MCO provides follow-up visits with the participant. The participant's parent or legal guardian is required to report any changes that occur generating updates as needed to adjust services. The participant and parent/legal guardian is involved in the development of the needs assessment with identified care needs and preferences. MCO coordinates other federal and state program resources, including services available to the child through Early Periodic Screening Diagnosis and Treatment (EPSDT) services in the development of the POC.

As part of the KanCare comprehensive managed care program, Kansas has worked with CMS to identify and utilize some transition safeguards for people using HCBS waiver services. Those safeguards are detailed in the Special Terms and Conditions associated with the 1115 KanCare program, and are summarized here as follows:

Safeguards related to mitigating conflict of interest in the development of service plans:

Kansas retains the responsibility for both initial and annual eligibility determinations for all HCBS programs, which Kansas will conduct via contractors or providers with state oversight. Kansas has contracted with three managed care organizations, to provide overall management of these services as one part of the comprehensive KanCare program. The MCO care coordinators are responsible for POC development. Kansas requires that conflict of interest be mitigated, and recognizes that the primary way in which that mitigation has been achieved is by separating from service providers, the plan of care development, and making that an MCO function. (In addition, conflict has been mitigated by Kansas separating the level of care determination from any service delivery or plan of care development.) Some of the additional safeguards that are in place to ensure that there is no conflict of interest in this function include the following operational strategies for each MCO:

For Amerigroup:

- Care managers (CM) and Service Coordinators (SC) do not have access to financial data such as the rates the providers are paid
- CM and SCs cannot adjudicate or adjust claims
- Policies and procedures focus on POCs being participant centered and providing choice among network providers
- Members get copies of the POC that provide the member the opportunity to identify mistakes and/or complain about CM/SC interaction
- Long-Term Services and Supports (LTSS) Participants sign their assessment on iPad
- Quality department monitors and trends complaints including those related to SCs
- Health Plan conducts CAHPS surveys that include opportunities for participants to express their satisfaction with CM/SC
- Health Plan selects a sample of participants per month, including those participating in LTSS, to send EOBs for services billed to conduct fraud surveillance and to drive complaints to the MCO as applicable if they are dissatisfied with their services
- MCO LTSS managers audits SC/CM to assure member driven service plans
- Participants can appeal decisions related to a reduction of HCBS and any other services
- MCO will submit a report to the state, on a for information basis, of members for whom any reduction in the service plan was made and excluding services that are reduced to conform with benefit or program limits, because a participant transitions out of a particular program HCBS program, loses eligibility, or other similar circumstance.

For United Healthcare:

All operations, including but not limited to the clinical operations and functions of every United Healthcare Community Plan are designed to ensure no conflict of interest with the Teams that are responsible for Plans of Care, service authorization, monitoring, payment and business management of the Health Plan. To this end, standard within the Kansas United Healthcare Community Plan the following safeguards exist:

- The State of KS (not United Healthcare Community Plan) retains the responsibility for member initial and annual eligibility determinations for waiver programs.
- United Healthcare Community Plan has developed a network of contracted HCBS providers to deliver waiver services & does not directly employ any HCBS providers.
- Service plans are developed based on member clinical and functional needs assessment (state approved); analysis of available informal supports, and standardized internal task/hour guidelines. Inter-rater reliability activities including joint member visits are conducted regularly by managers to assure consistency & accuracy of the assessment & service plan development process.
- HCBS provider selection is driven by member choice from the network, and if no member preference exists, referrals are made to network providers in the closest geographic proximity who are able to meet the member's preferred schedule.
- Prior authorizations are required for all HCBS services and submitted by the assigned care coordinator. A utilization management team separate from the care coordination team completes final reviews of the authorization to assure that the member is eligible for the requested waiver service and that the documentation supports the proposed service plan. Inter-rater reliability activities are also conducted regularly with the utilization management team.
- The Team that conducts care coordination and Plan of Care development is different from the Team that authorizes care and they have different reporting structures.
- All UnitedHealthcare health plans including the Kansas UnitedHealthcare Community Plan offer no compensation for any clinical staff that creates incentives for activities that would deny, limit, or discontinue medically necessary services to any member. Plan of Care development and service authorization decisions are based on appropriateness of care and existence of coverage.

For Centene/Sunflower: Conflict of Interest Safeguards

#### Safeguards

Sunflower State Health Plan's operations, including but not limited to the clinical operations and functions, are designed to ensure no conflict of interest exist between the teams that are responsible for Service Plans or Plan of Care, service authorization, monitoring, payment and business management of the Health Plan.

#### HCBS Providers Independence & Member Choice

Sunflower State Health Plan has developed a network of contracted HCBS providers to deliver waiver services and does not directly employ any HCBS providers.

Sunflower State works with the members to ensure member choice from our contracted network of providers. HCBS

provider selection is driven by member choice from the network, and if no member preference exists, referrals are made to network providers in the closest geographic proximity who are able to meet the member's preferred schedule. The Case Manager will work closely with the member and our provider network to meet the member's service plan or plan of care.

#### Services Plans

Service Plans are developed based on member clinical and functional assessment tools directed by the state, analysis of support system/community, utilization of members ADLs and IADL measurement, and leveling of care to determine and standardize tasking/hour guidelines for members' Service Plans. Case Management Managers and Director for Waiver programs, will conduct Case Management inter rater reliability ensuring consistency of case management's assessment and Service Plan development. This will be ongoing, reflecting improvement of and training of staff.

Prior authorizations are required for all HCBS services and submitted by the assigned care coordinator. The Medical Management team will meet to discuss HCBS service plan ensuring member's eligibility for the requested services.

Review of the HRA assessment and additional measuring tools define and support service plan needs. Inter rater reliability activities and training continues ongoing. The Medical Management team consists of CM Manager, BH, Social Worker, RN Case Manager and Medical Director when appropriate regarding the development of care planning and services.

Service Plan development and service authorization decisions are based on appropriateness of care and existence of coverage. Sunflower's State Health Plan Care Manager team base service authorizations on appropriateness of care and benefit coverage with the development of the member's Service Plan.

#### Role Based Security

Sunflower State Health Plan has in place role-based security to ensure no conflict of interest between the Service Plan or Plan of Care development and claims payment. Role based access control (RBAC) allows Sunflower to assign access to our Management Information Systems, in this case TruCare and Amisys Advance, to appropriately authorized personnel based on specific job roles. The claims processing team and clinical teams are two separate functional areas with different job roles and security. For Sunflower, the plans of care are developed in Kansas and the claims are processed in Great Falls, MT.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (5 of 8)

- e. Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

The child's plan of care (POC) takes into account information from the FEI assessment which identifies potential risk factors, and informal supports and other non-waiver services. The POC will contain, at a minimum, the type of services to be furnished, the amount, the frequency and duration of each service, and the type of provider to furnish each service, including informal services and providers. The POC is the fundamental tool by which the State will ensure the health and welfare of the children/families receiving services under this waiver. The POC will be subject to periodic review and update. Reviews will take place to determine the appropriateness and adequacy of the services, and to ensure that the services furnished are consistent with the nature and severity of the child's disability. Each child's plan of care identifies potential risks; identifies emergency contact information; and a back-up plan to maintain both formal and informal services and supports. Back up plans are based on the needs of the child/family. Examples of back up plans could include evacuation planning and /or backup staff in the event scheduled staff would not be available to work. The MCO care coordinator discloses to the family that if an individual provider of services (non-agency employee) is not available to work the family will bear the liability of staffing the waiver hours to meet health and safety to the child.

All families are responsible, with the assistance of the MCO, for ensuring that a back-up plan is in place to ensure the health and safety of the waiver participant is met in the event a service provider unavailable. KanCare MCOs must maintain adequate back-up plans for all waiver participants in the event that a provider is unavailable. Currently family members are prohibited from being paid direct services providers under the HCBS-Autism waiver.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (6 of 8)

**f. Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

If the participant chooses to receive waiver services, the MCO provides a list of all service access agencies to the participant and assists with accessing information and supports from the participant's preferred qualified provider. These service access agencies have and make available to the participant the names and contact information of qualified providers of the waiver services identified in the POC.

After the MCO care coordinator has met with the child/family, developed the plan of care (POC) identified waiver services that will be utilized by the child/family, the MCO care coordinator will provide a list of service providers identified from his/her written plan from which the child/family can choose. The child/family can choose to change service providers at any time during the delivery of services.

Family choice is offered at least annually, (re-evaluation) regardless of current provider, or other life choice decision points, or any time at the request of the child/family.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (7 of 8)

**g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

The MCO and the child/family develop a plan of care. This plan is then submitted to the contracted MCO of choice for plan of care approval.

The MCO is responsible for maintaining a copy of an electronic or paper plan of care is to be maintained in the child's file.

Engagement of the interagency monitoring team, brings together leadership, program management, contract management, fiscal management and other staff/resources of the SSMA and the Operating Agency to collectively monitor the extensive reporting, review results and other quality information and data related to the KanCare program and services on a quarterly basis.

The State Operating Agency Quality Management Staff (QMS) conducts routine oversight of service plans including: On-site reviews are conducted, at a minimum, annually. The State Operating Agency QMS conduct ongoing reviews based upon a statistically valid random sample of service plans, at a minimum quarterly. Critical components of the SSMA and Operating Agency's role in service plan development include:

1. Engagement of the interagency monitoring team, which meets quarterly and brings together agency leadership, program management, contract management, fiscal management and other staff/resources of the SSMA and the Operating Agency to collectively monitor the extensive reporting, review results and other quality information and data related to the KanCare program and services.
2. Continuance of the Long Term Committee where the Operating Agency reports quality assurance and programmatic activities to SSMA for oversight and collaboration..

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (8 of 8)

**h. Service Plan Review and Update.** The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review



and update of the service plan:

**Every three months or more frequently when necessary**

**Every six months or more frequently when necessary**

**Every twelve months or more frequently when necessary**

**Other schedule**

*Specify the other schedule:*

**i. Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following (*check each that applies*):

**Medicaid agency**

**Operating agency**

**Case manager**

**Other**

*Specify:*

The Eligibility Specialist maintains copies of the original FEI, freedom of choice forms, and the Rights and Responsibilities forms.

The KanCare MCOs maintain the copies of the above mentioned information as well as any additional forms such as; the child/family strengthens and needs assessment, individualized behavioral program and plan of care, detail progress notes, etc., In the child's case file.

Copies are maintained for a minimum period of 3 years as required by 45 CFR 74.53

## **Appendix D: Participant-Centered Planning and Service Delivery**

### **D-2: Service Plan Implementation and Monitoring**

**a. Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The three KanCare contracting managed care organizations are responsible for monitoring the implementation of the Plan of Care that was developed as a partnership between the participant and the MCO and for ensuring the health and welfare of the participant with input from the Autism Program Manager, involvement of KDADS Regional Field Staff, and assessed with the comprehensive statewide KanCare quality improvement strategy (which includes all of the HCBS waiver performance measures).

On an ongoing basis, the MCOs monitor the Plan of Care and participant needs to ensure:

- Services are delivered according to the Plan of Care;
- Participants have access to the waiver services indicated on the Plan of Care;
- Participants have free choice of providers;
- Services meet participant's needs;
- Liabilities with self-direction (if applicable)/agency-direction are discussed, and back-up plans are effective;
- Participant's health and safety are assured, to the extent possible; and
- Participants have access to non-waiver services that include health services.

The Plan of Care is the fundamental tool by which the State will ensure the health and welfare of participants served under this waiver. The KanCare MCOs, who deliver no direct waiver services to waiver participants, are responsible for both the initial and updated plans of care.

In-person monitoring by the MCOs is ongoing:

- Choice and monitoring are offered at least annually, regardless of current provider or self-direction, or at other life choice decision points, or any time at the request of the participant.
- Choice is documented.
- The Plan of Care is modified to meet change in needs, eligibility, or preferences, or at least annually.

In addition, the Plan of Care and choice are monitored by state quality review and/or performance improvement staff as a component of waiver assurance and minimum standards. Issues found needful of resolution are reported to the MCO and waiver provider for prompt follow-up and remediation. Related information is reported to the Autism Program Manager. Service plan implementation and monitoring performance measures and related collection/reporting protocols, together with others that are part of the KanCare MCO contract, are included in a statewide comprehensive KanCare quality improvement strategy which is regularly reviewed and adjusted. That plan is contributed to and monitored through a state interagency monitoring team, which includes HCBS waiver program managers, fiscal staff and other relevant staff/resources from both the state Medicaid agency and the state operating agency.

State staff request, approve, and assure implementation of contractor/provider corrective action planning and/or technical assistance to address non-compliance with performance standards as detected through on-site monitoring, MCO compliance monitoring, survey results and other performance monitoring. These processes are monitored by both contract managers and other relevant state staff, depending upon the type of issue involved, and results tracked consistent with the statewide quality improvement strategy and the operating protocols of the interagency monitoring team.

**b. Monitoring Safeguards. *Select one:***

**Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**

**Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

## Appendix D: Participant-Centered Planning and Service Delivery

### Quality Improvement: Service Plan

*As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.*

**a. Methods for Discovery: Service Plan Assurance/Sub-assurances**

*The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans*

for waiver participants.

**i. Sub-Assurances:**

- a. Sub-assurance: Service plans address all participants assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.**

**Performance Measures**

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

**Performance Measure:**

**Number and percent of waiver participants whose service plans address all of each participant's health and safety risk factors**  
**N=Number of waiver participants whose service plans address all of each participant's health and safety risk factors**

**D=Number of waiver participants whose service plans were reviewed**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Record reviews**

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <div>95%</div>
<b>Other</b> Specify: <div>KanCare Managed Care Organizations (MCOs)</div>	<b>Annually</b>	<b>Stratified</b> Describe Group: <div>Proportionate by MCO</div>
	<b>Continuously and</b>	<b>Other</b>

	<b>Ongoing</b>	Specify: <div></div>
	<b>Other</b> Specify: <div></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <div>KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency</div>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <div></div>

**Performance Measure:**

**Number and percent of waiver participants whose service plans address all of each participant's assessed needs and capabilities as indicated in the assessment**

**N=Number of waiver participants whose service plans address all of each participant's assessed needs and capabilities as indicated in the assessment**

**D=Number of waiver participants whose service plans were reviewed**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Record reviews**

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <div>95%</div>
<b>Other</b> Specify: <div>KanCare Managed Care Organizations (MCOs)</div>	<b>Annually</b>	<b>Stratified</b> Describe Group: <div>Proportionate by MCO</div>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <div></div>
	<b>Other</b> Specify: <div></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:	<b>Annually</b>

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency	
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

**Performance Measure:**

Number and percent of waiver participants whose service plans address all of each participants' personal goals N=Number of waiver participants whose service plans address all of each participants' personal goals D=Number of waiver participants whose service plans were reviewed

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Record reviews**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <div style="border: 1px solid black; padding: 2px; display: inline-block;">95%</div>
<b>Other</b> Specify: <div style="border: 1px solid black; padding: 2px; display: inline-block;">KanCare Managed Care Organizations</div>	<b>Annually</b>	<b>Stratified</b> Describe Group: <div style="border: 1px solid black; padding: 2px; display: inline-block;">Proportionate by MCO</div>
	<b>Continuously and</b>	<b>Other</b>

	<b>Ongoing</b>	Specify: <div></div>
	<b>Other</b> Specify: <div></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <div>KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency</div>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <div></div>

- b. Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.**

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**

**Number and percent of waiver participants whose service plans were developed according to the processes in the approved waiver** N=Number of waiver participants whose service plans were developed according to the processes in the approved waiver D=Number of waiver participants whose service plans were reviewed

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Record reviews**

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <div>95%</div>
<b>Other</b> Specify: <div>KanCare Medicaid Care Organizations</div>	<b>Annually</b>	<b>Stratified</b> Describe Group: <div>Proportionate by MCo</div>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <div></div>
	<b>Other</b> Specify: <div></div>	

**Data Aggregation and Analysis:**



<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> KanCare MCOs participate in the analysis of this measure's results as determined by the State operating agency </div>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <div style="border: 1px solid black; height: 30px; margin-top: 10px;"></div>

**Performance Measure:**

**Number and percent of waiver participants (or their representatives) who were present and involved in the development of their service plan**  $N = \text{Number of waiver participants (or their representatives) who were present and involved in the development of their service plan}$   $D = \text{Number of waiver participants whose service plans were reviewed}$

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Record reviews**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval =

		95%
<b>Other</b> Specify:  <div>KanCare Managed  Care Organizations  (MCOs)</div>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <div>Proportionate  by MCo</div>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  <div></div>
	<b>Other</b> Specify:  <div></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:  <div>KanCare MCOs participate in the analysis of this measure's results as determined by the State operating agency</div>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:  <div></div>

- c. **Sub-assurance:** *Service plans are updated/revised at least annually or when warranted by changes in the waiver participants needs.*

### Performance Measures

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

### Performance Measure:

**Number and percent of waiver participants with documented change in needs whose service plan was revised, as needed, to address the change**  
 $N = \text{Number of waiver participants with documented change in needs whose service plan was revised, as needed, to address the change}$   
 $D = \text{Number of waiver participants whose service plans were reviewed}$

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Record reviews**

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <div>95%</div>
<b>Other</b> Specify: <div>KanCare Managed Care Organizations (MCOs)</div>	<b>Annually</b>	<b>Stratified</b> Describe Group: <div>Proportionate by MCO</div>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:

		<input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

Number and percent of service plans reviewed before the waiver participant's annual redetermination date N=Number of service plans reviewed before the waiver participant's annual redetermination date D=Number of waiver participants whose service plans were reviewed

**Data Source** (Select one):**Other**

If 'Other' is selected, specify:

**Record reviews**

<b>Responsible Party for data collection/generation</b>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
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<i>(check each that applies):</i>		
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <div>95%</div>
<b>Other</b> Specify: <div>KanCare Managed Care Organizations (MCOs)</div>	<b>Annually</b>	<b>Stratified</b> Describe Group: <div>Proportionate by MCO</div>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <div></div>
	<b>Other</b> Specify: <div></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:	<b>Annually</b>

<b>Responsible Party for data aggregation and analysis</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency	
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

- d. *Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.*

#### Performance Measures

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

#### Performance Measure:

**Number and percent of waiver participants who received services in the type, scope, amount, duration, and frequency specified in the service plan**  
 $N = \text{Number of waiver participants who received services in the type, scope, amount, duration, and frequency specified in the service plan}$   
 $D = \text{Number of waiver participants whose service plans were reviewed}$

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Record reviews and Electronic Visit Verification (EVV) reports, if applicable**

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative</b>

		<b>Sample</b> Confidence Interval = <div>95%</div>
<b>Other</b> Specify: <div>KanCare Managed Care Organizations (MCOs)</div>	<b>Annually</b>	<b>Stratified</b> Describe Group: <div>Proportionate by MCO</div>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <div></div>
	<b>Other</b> Specify: <div></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <div>KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency</div>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):

**Performance Measure:**

**Number and percent of survey respondents who reported receiving all services as specified in their service plan** N=Number of survey respondents who reported receiving all services as specified in their service plan D=Number of waiver participants interviewed by QMS staff

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Customer interviews - on site**

<b>Responsible Party for data collection/generation</b> ( <i>check each that applies</i> ):	<b>Frequency of data collection/generation</b> ( <i>check each that applies</i> ):	<b>Sampling Approach</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <div>95%</div>
<b>Other</b> Specify: <div></div>	<b>Annually</b>	<b>Stratified</b> Describe Group: <div>Proportionate by MCO</div>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <div></div>
	<b>Other</b> Specify:	



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**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> KanCare MCOs participate in analysis of this measure's results as determined by the Sate operating agency </div>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <div style="border: 1px solid black; height: 30px; margin-top: 10px;"></div>

**e. Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.****Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**

**Number and percent of waiver participants whose record contains documentation indicating a choice of community-based services v. an institutional alternative**

**N=Number of waiver participants whose record contains documentation indicating a choice of community-based services D=Number of waiver participants whose files are reviewed for the documentation**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Record reviews**

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <div>95%</div>
<b>Other</b> Specify: <div>KanCare Managed Care Organizations (MCOs)</div>	<b>Annually</b>	<b>Stratified</b> Describe Group: <div>Proportionate by MCO</div>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <div></div>
	<b>Other</b> Specify: <div></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b>	<b>Annually</b>

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
Specify:  <div style="border: 1px solid black; padding: 5px; width: fit-content;">           KanCare MCOs participate in the analysis of this measure's results as determined by the State Operating Agency         </div>	
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:  <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

**Performance Measure:**

**Number and percent of waiver participants whose record contains documentation indicating a choice of waiver services**  
 $N = \text{Number of waiver participants whose record contains documentation indicating a choice of waiver services}$   
 $D = \text{Number of waiver participants whose files are reviewed for the documentation}$

**Data Source** (Select one):**Other**

If 'Other' is selected, specify:

**Record reviews**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval =  <div style="border: 1px solid black; padding: 2px; width: 100px; text-align: center;">95%</div>
<b>Other</b> Specify:	<b>Annually</b>	<b>Stratified</b> Describe Group:  <div style="border: 1px solid black; padding: 2px; width: 100px; text-align: center;">Proportionate by MCO</div>

KanCare Managed Care Organizations (MCOs)		
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <div></div>
	<b>Other</b> Specify: <div></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <div>KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency</div>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <div></div>

**Performance Measure:**

**Number and percent of waiver participants whose record contains documentation indicating a choice of waiver service providers** N=Number of waiver participants whose record contains documentation indicating a choice of waiver service providers  
D=Number of waiver participants whose files are reviewed for the documentation

**Data Source** (Select one):**Other**

If 'Other' is selected, specify:

**Record reviews**

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <div>95%</div>
<b>Other</b> Specify: <div>KanCare Managed Care Organizations (MCOs)</div>	<b>Annually</b>	<b>Stratified</b> Describe Group: <div>Proportionate by MCO</div>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <div></div>
	<b>Other</b> Specify: <div></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b>	<b>Annually</b>

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
Specify:  <div data-bbox="405 338 799 488" style="border: 1px solid black; padding: 5px;"> KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency </div>	
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:  <div data-bbox="868 685 1262 768" style="border: 1px solid black; height: 37px; width: 247px;"></div>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Kansas Department of Health and Environment, Division of Health Care Finance (KDHE), the single state Medicaid agency, and Kansas Department for Aging and Disability Services (KDADS) work together to develop state operating agency priority identification regarding all waiver assurances and minimum standards/basic assurances. The state agencies work in partnership with participants, advocacy organizations, provider groups and other interested stakeholders to monitor the state quality strategy and performance standards and discuss priorities for remediation and improvement. The state quality improvement strategy includes protocols to review cross-service system data to identify trends and opportunities for improvement related to all Kansas waivers, policy and procedure development and systems change initiatives.

Data gathered by KDADS Regional Staff during the Quality Survey Process, and data provided by the KanCare MCOs, is compiled quarterly for evaluation and trending to identify areas for improvement. Upon completion of identified areas of improvement this information is compiled into reports and shared both internally and externally, including with KDHE. These measures and collection/reporting protocols, together with others that are part of the KanCare MCO contract, are included in a statewide comprehensive KanCare quality improvement strategy which is regularly reviewed and adjusted. That plan is contributed to and monitored through a state interagency monitoring team, which includes program managers, fiscal staff and other relevant staff/resources from both the state Medicaid agency and the state operating agency.

KDADS Quality Assurance field staff have file review protocol questions to assess whether service plans include waiver processes, such as:

- Providing Choice;
- Rights & Responsibilities;
- Notice Of Action for adverse actions, terminations, denials or change in service plans;
- Service plan includes goals;
- Addresses health and safety risks and needs; and
- Consumer involvement

: If a case is found to have a “defect,” the state would note that measure as not being met. An example of a “defect” or non-compliant measure could include but may not be limited to:

- Doesn’t appear the service plan adequately addressed the needs, or health or safety risks; or goals.
- No evidence (i.e. signature/date of consumer) the consumer participated and was involved in the development of their service plan.

The State reviews 25% Autism cases quarterly, with a 100% annual review for the Autism Waiver.

MCOs are required to monitor service plan development of contracted providers as part of their ongoing quality process. The State completes, at a minimum, annual record reviews for the Autism Waiver oversight to overall service plan development of MCOs and contracted providers.

## **b. Methods for Remediation/Fixing Individual Problems**

- i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

State staff and/or KanCare MCO staff request, approve, and assure implementation of provider corrective action planning and/or technical assistance to address non-compliance with waiver and performance standards as detected through on-site monitoring, survey results and other performance monitoring. These processes are monitored by both program managers and other relevant state and MCO staff, depending upon the type of issue involved, and results tracked consistent with the statewide quality improvement strategy and the operating protocols of the interagency monitoring team.

Monitoring and survey results are compiled, trended, reviewed, and disseminated consistent with protocols identified in the statewide quality improvement strategy. Each provider receives annual data trending which identifies Provider specific performance levels related to statewide performance standards and statewide averages. Corrective Action Plan requests, technical assistance and/or follow-up to remediate negative trending are included in annual provider reports where negative trending is evidenced.

**ii. Remediation Data Aggregation****Remediation-related Data Aggregation and Analysis (including trend identification)**

<b>Responsible Party</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:  <div style="border: 1px solid black; padding: 2px; width: fit-content;">KanCare Managed Care Organizations (MCOs)</div>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:  <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

**No**

**Yes**

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

## Appendix E: Participant Direction of Services

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**Applicability** *(from Application Section 3, Components of the Waiver Request):*

**Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.

**No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

*CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.*

**Indicate whether Independence Plus designation is requested** *(select one):*

**Yes. The state requests that this waiver be considered for Independence Plus designation.**

**No. Independence Plus designation is not requested.**



**Appendix E: Participant Direction of Services**

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**E-1: Overview (1 of 13)**

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (2 of 13)**

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (3 of 13)**

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (4 of 13)**

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (5 of 13)**

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (6 of 13)**

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (7 of 13)**

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (8 of 13)**

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (9 of 13)**

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (10 of 13)**

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (11 of 13)**

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (12 of 13)**

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (13 of 13)**

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

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**E-2: Opportunities for Participant Direction (1 of 6)**

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

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**E-2: Opportunities for Participant-Direction (2 of 6)**

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

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**E-2: Opportunities for Participant-Direction (3 of 6)**

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

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**E-2: Opportunities for Participant-Direction (4 of 6)**

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

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**E-2: Opportunities for Participant-Direction (5 of 6)**

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix E: Participant Direction of Services**

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**E-2: Opportunities for Participant-Direction (6 of 6)**

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Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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**Appendix F: Participant Rights**

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**Appendix F-1: Opportunity to Request a Fair Hearing**

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The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied,

suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

**Procedures for Offering Opportunity to Request a Fair Hearing.** Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Kansas utilizes contracted assessors to conduct level of care determinations state wide. Decisions made by the FES are subject to state fair hearing review, and notice of that right and related process will be provided by the contracted FES with their decision on the LOC determination/redetermination.

Kansas contracts with three KanCare managed care organizations (MCOs) that are required to have grievance and appeal processes that meet all relevant federal and state standards, including state fair hearings and expedited appeals. Each MCO has established operational processes regarding these issues, about which they must inform every member. In addition, the State reviews member grievances/appeals on an ongoing basis. The State reports to CMS the number and frequency of these types of complaints/grievances and will continue to monitor throughout the KanCare program.

Each member is provided information about grievances, appeals and fair hearings in their KanCare member enrollment packet. A grievance is any expression of dissatisfaction about any matter other than an Action. Grievances can be filed in writing or verbally. Grievances will be acknowledged by MCOs in writing within 10 business days of receipt, and a written response to the grievance will be given to the member within 30 business days (except in cases where it is in the best interest of the member that the resolution timeframe be extended). In addition to filing grievances, KanCare members have the right to submit a request for a fair hearing.

All KanCare members are advised the following regarding appeals and state fair hearings:

"An appeal can only occur under the following circumstances:

- If an Action has occurred. An Action is the denial of services or a limitation of services, including the type of service; the reduction, suspension, or termination of a service you have been receiving; the denial, in whole or part, of payment for a service; or the failure of the health plan to act within established time requirements for service accessibility.
- You will receive a Notice of Action in the mail if an Action has occurred.
- An Appeal is a request for a review of any of the above actions.
- To file an Appeal: You, your friend, your attorney, or anyone else on your behalf can file an appeal.
- An appeal can be filed verbally, but it must be followed by a written request. The Customer Service Center for your health plan can also help you with an appeal.
- An appeal must be filed within 30 calendar days after you have received a Notice of Action.
- The appeal will be resolved within 30 calendar days unless more time is needed. You will be notified of the delay, but your appeal will be resolved in 45 calendar days.

The information regarding continuance of service is available to the participant on the MCO's notice action or the member's handbook.

You have other options for a quicker review of your appeal. Call your health plan for more information."

#### Fair Hearings

A Fair Hearing is a formal meeting where an impartial person (someone you do not know), assigned by the Office of Administrative Hearings, listens to all of the facts and then makes a decision based on the law.

- If you are not satisfied with the decision made on your appeal, you or your representative may ask for a fair hearing. It must be done in writing and mailed or faxed to:

Office of Administrative Hearings

1020 S. Kansas Ave.

Topeka, KS 66612-1327

Fax: 785-296-4848

- The letter or fax must be received within 30 days of the date of the appeal decision.

Members have the right to benefits while a hearing is pending, and can request such benefits as part of their fair hearing request. All three MCOs will advise members of their right to a State Fair Hearing. Members do not have to finish their appeal with the MCO before requesting a State Fair Hearing.

Addressing specific additional elements required by CMS:

I. How individuals are informed of the Fair Hearing process during entrance to the waiver including how, when and by whom this information is provided to individuals.

For all KanCare MCOs: In addition to the education provided by the State, members receive information about the Fair Hearing

process in the member handbook they receive at the time of enrollment. The member handbook is included in the welcome packet provided to each member. It will also be posted online at the MCOs' member web site. In addition, every notice of action includes detailed information about the Fair Hearing process, including timeframes, instructions on how to file, and who to contact for assistance. And, at any time a member can call the MCO to get information and assistance with the Fair Hearing process.

II. All instances when a notice must be made to an individual of an adverse action including: 1) choice of HCBS vs. institutional services, 2) choice of provider or service, and 3) denial, reduction, suspension or termination of service.

The state requires that all MCOs define an "action" pursuant to KanCare RFP Attachment C and 42 CFR §438.400. While the State determines, including through contracting entities, eligibility for HCBS waivers and is responsible for notifying an individual of an adverse action in the event that their application (choice of HCBS vs. institutional services) is denied, MCOs issue a notice of adverse action under the following circumstances:

- The denial or limited authorization of a requested service, including the type or level of service;
- The reduction, suspension, or termination of a previously authorized service;
- The denial, in whole or in part, of payment for a service;
- The failure to provide services in a timely manner;
- The failure of an Amerigroup to act within the timeframes provided in 42 CFR §438.408(b); and
- For a resident of a rural area with only one MCO, the denial of a Medicaid enrollee's request to exercise his or her right, under 42 CFR §438.52(b)(2)(ii), to obtain services outside the network.

III. How notice of adverse action is made.

Amerigroup: Once the decision is made, the Medical Director notifies the Health Care Management Services department of the decision by routing the authorization request to specified queues within Amerigroup's system of record (Facets). An Amerigroup Utilization Management nurse reviews the decision, makes any necessary updates to the authorization and routes it to the designated decision queue in Facets. The Case Specialist assigned to the queue will create the letter in Amerigroup's document repository system (Macess) under the member's account and send to the Amerigroup Document Control Center (DCC) for mailing to both the member and the provider.

Sunflower: Sunflower will issue notice of adverse actions in writing. The notice of action letters utilized by Sunflower will have the prior written approval of KDHE before they are used. Written notification of adverse action may also be supplemented with telephonic and/or face-to-face notifications if necessary.

United: A Notice of Action is provided in writing to the member with a cc: to the provider.

IV. The entity responsible for issuing the notice

Amerigroup: Case Specialists in the Amerigroup Health Care Management Services Department are responsible for issuance of the notice (which includes the Amerigroup Medical Director's signature). These notices are sent from the Case Specialist to Amerigroup's Document Control Center for mailing.

Sunflower: Sunflower State Health Plan is responsible for issuing notifications to its enrolled members. Subcontracted entities who may be delegated appeal may also issue Notice of Action letters to members who are denied or received reduction of services that the delegated entity provides. All of the Sunflower's subcontracted entities will use the previously approved notice of action and grievance/appeal process letters that Sunflower uses.

United: UnitedHealthcare Community Plan will be issuing the notices.

V. The assistance (if any) that is provided to individuals in pursuing a Fair Hearing.

Amerigroup: The Amerigroup Quality Management Department includes Member Advocates that are dedicated to tasks such as helping members file grievances, appeals and Fair Hearings. If a member calls the Amerigroup Member Services line to request assistance with a Fair Hearing, our call center provides a transfer to the Member Advocate who assists the member.

Sunflower: Sunflower's Member Service Representative, Grievance and Appeals Coordinators and Care Managers will all be available to provide personal assistance to members needing support at any stage of the grievance process including Fair Hearing. They will provide information to members about their rights, how access the Fair Hearing process, provide assistance in completing any required documentation and provide all information relevant to the issue giving rise to the need for a Fair Hearing. In addition, Members will have access to communication assistance such as translation, TTY/TTD availability, interpreter services or alternative formats for member materials.

United: UnitedHealthcare has Member Advocates who can provide general assistance and a Plan Grievance Coordinator who is available to assist members with filing the request and who will prepare the files for submission to the State.

VI. Specify where notices of adverse action and the opportunity to request a Fair Hearing are kept.

Amerigroup: Template Notice of Adverse Action letters are housed in Amerigroup's electronic document repository system (Macess). When individual letters are created, they are saved in the member's individual folder within this system. All these

letters include notification of the opportunity to request a Fair Hearing.

Sunflower: Sunflower will maintain records of all notices of adverse action letters issued to members, with the required Fair Hear rights and process language, in our TruCare Medical Management application and in our Customer Relations Management (CRM) application used to track and report events in the grievance process.

United: Notice of Action letters are maintained in corporate letter archives. They are tied to the notification number in our CareOne Medical Management System. They are indexed by State, date of notice, member name, product (i.e. Medicaid) and notification number.

## Appendix F: Participant-Rights

### Appendix F-2: Additional Dispute Resolution Process

- a. Availability of Additional Dispute Resolution Process.** Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

**No. This Appendix does not apply**

**Yes. The state operates an additional dispute resolution process**

- b. Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

## Appendix F: Participant-Rights

### Appendix F-3: State Grievance/Complaint System

- a. Operation of Grievance/Complaint System.** *Select one:*

**No. This Appendix does not apply**

**Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

- b. Operational Responsibility.** Specify the state agency that is responsible for the operation of the grievance/complaint system:

Under the KanCare program, nearly all Medicaid services - including nearly all HCBS waiver services - are provided through one of the three contracting managed care organizations. However, for those situations in which the participant is not a KanCare member, this grievance/complaint system applies. The Single State Medicaid Agency, Kansas Department of Health and Environment (KDHE) employs the fiscal agent to operate the participant complaint and grievance system. (A description as to how KanCare members are informed that filing a grievance is not a prerequisite for a Fair Hearing is included at Appendix F.1.)

- c. Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The fiscal agent is open to any complaint, concern, or grievance a participant has against a Medicaid provider. The Consumer Assistance Unit staff logs and tracks all complaints, concerns, or grievances. If a provider has three complaints lodged against them, an investigation is initiated. KDHE and KDADS have access to this information at any time.

The Medical Assistance Customer Service Center (MACSC) at the fiscal agent is open to any complaint, concern, or grievance a consumer has against a Medicaid provider. The Consumer Assistance Unit staff logs and tracks all complaints, concerns, or grievances. If a provider has a grievance lodged against them, an investigation is initiated. KDHE and KDADS have access to this information at any time.

The MACSC transfers grievances to the Quality Assurance Team (QAT) on the date received. QAT has three (3) days to contact the grievant to acknowledge the grievance and thirty (30) days to complete the research and resolution. If more time is needed, QAT must request additional time from the state Program Manager. QAT trends grievances on a monthly basis. Criterion for further research is based on number of grievances per provider in a specific time frame.

Participants who are not part of the KanCare program are educated that lodging a complaint and/or grievance is not a prerequisite or substitute for a Fair Hearing and is a separate activity from a Fair Hearing. This information may also be provided by the Autism Waiver Program Manager.

## Appendix G: Participant Safeguards

### Appendix G-1: Response to Critical Events or Incidents

- a. Critical Event or Incident Reporting and Management Process.** Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program. *Select one:*

**Yes. The state operates a Critical Event or Incident Reporting and Management Process** (*complete Items b through e*)

**No. This Appendix does not apply** (*do not complete Items b through e*)

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

- b. State Critical Event or Incident Reporting Requirements.** Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The state provides for the reporting and investigation of the following major and serious incidents:

Article 22, Kansas Code for Care of Children defines:

Article 22: Revised Kansas Code For Care Of Children

Statute 38-2202: Definitions. As used in the revised Kansas code for care of children, unless the context otherwise indicates:

- (a) "Abandon" or "abandonment" means to forsake, desert or, without making appropriate provision for substitute care, cease providing care for the child.
- (b) "Adult correction facility" means any public or private facility, secure or non-secure, which is used for the lawful custody of accused or convicted adult criminal offenders.
- (c) "Aggravated circumstances" means the abandonment, torture, chronic abuse, sexual abuse or chronic, life threatening neglect of a child.
- (d) "Child in need of care" means a person less than 18 years of age at the time of filing of the petition or issuance of an ex parte protective custody order pursuant to K.S.A. 2009 Supp. 38-2242, and amendments thereto, who:
  - (1) is without adequate parental care, control or subsistence and the condition is not due solely to the lack of financial means of the child's parents or other custodian;
  - (2) Is without the care or control necessary for the child's physical, mental or emotional health;
  - (3) Has been physically, mentally or emotionally abused or neglected or sexually abused;
  - (4) Has been placed for care or adoption in violation of law;
  - (5) Has been abandoned or does not have a known living parent;
  - (6) Is not attending school as required by K.S.A. 72-977 or 72-1111 and amendments thereto;
  - (7) except in the case of a violation of K.S.A. 21-4204a, 41-727, subsection (j) of K.S.A. 74-8810 or subsection (m) or (n) of K.S.A. 79-3321, and amendments thereto, or, except as provided in paragraph (12), does an act which, when committed by a person under 18 years of age, is prohibited by state law, city ordinance or county resolution but which is not prohibited when done by an adult;
  - (8) While less than 10 years of age, commits any act which if done by an adult would constitute the commission of a felony or misdemeanor as defined by K.S.A. 21-3105, and amendments thereto;
  - (9) Is willfully and voluntarily absent from the child's home without the consent of the child's parent or other custodian;
  - (10) is willfully and voluntarily absent at least a second time from a court ordered or designated placement, or a placement pursuant to court order, if the absence is without the consent of the person with whom the child is placed or, if the child is placed in a facility, without the consent of the person in charge of such facility or such person's designee;
  - (11) has been residing in the same residence with a sibling or another person under 18 years of age, who has been physically, mentally or emotionally abused or neglected, or sexually abused;
  - (12) While less than 10 years of age commits the offense defined in K.S.A. 21-4204a, and amendments thereto; or
  - (13) Has had a permanent custodian appointed and the permanent custodian is no longer able or willing to serve.

Kansas statute (K.S.A. 3-1431), Reporting of certain abuse or neglect of children; persons reporting; reports, made to whom; penalties for failure to report or interference with making a report. a)When any of the following persons has reason to suspect that a child has been injured as a result of physical, mental, or emotional abuse or neglect or sexual abuse, the person shall report the matter promptly as provided in subsection (c) or (e): Person licensed to practice the healing arts or dentistry; persons licensed to practice optometry; persons engaged in postgraduate training programs approved by the state board of healing arts; licensed psychologists; licensed masters level psychologists; licensed clinical psychotherapists; licensed professional or practical nurses examining attending or treating a child under the age of 18; teachers, school administrators or other employees of a school which the child is attending; chief administrative officers of medical care facilities; licensed marriage and family therapists; licensed clinical marriage and family therapists; licensed professional counselors; registered alcohol and drug abuse counselors; person licensed by the secretary of health and environment to provide child care services or the employees of persons licensed at the place where the child care services are being provided to the child; licensed social workers; firefighters; emergency medical services personnel; mediators appointed under K.S. A 23-602 and amendments thereto; juvenile intake and assessment workers; and law enforcement officers.

The State of Kansas requires reporting of any suspected Abuse, Neglect, Exploitation or Fiduciary Abuse to DCF for review and follow-up within a reasonable time frame. Based on the age of the child, nature of the allegation, continued access of the perpetrator to the child, and other factors, department personnel establish the maximum response time for the report. If the report alleges that a child is in immediate, serious, physical danger, the DCF case work must take immediate action and/or request law enforcement assistance. If the report alleges that a child is not in immediate, serious,



physical danger, but the report alleges critical neglect or physical/sexual abuse, DCF must respond within 72 hours. If the report alleges that a child is not in immediate, serious, physical danger and the report does not allege physical or sexual abuse or neglect, DCF must respond within 20 working days.

Reporters can call the Kansas Protection Report Center in-state toll free at 1-800-922-5330. Telephone lines are staffed in the report center 24 hours a day, including holidays. In the event of an emergency, a report can be made to local law enforcement or 911. Anyone who suspects a child is experiencing any of the above types of critical incidents may report it through the DCF hotline.

The report may be made orally and shall be followed by a written report if requested. When the suspicion is the result of medical examination or treatment of a child by a member of the staff of a medical care facility or similar institution, that the staff member shall immediately notify the superintendent, manager or other person in charge of the institution who shall make a written report forthwith. Every written report shall contain if known, the names and addresses of the child and the child's parents or other persons responsible for the child's care, the child's age, the nature and extent of the child's injury (including any evidence of previous injuries) and any other information that the maker of the report believes might be helpful in establishing the cause of the injuries and the identity of the persons responsible for the injuries. (b) Any other person who has reason to suspect that a child has been injured as a result of physical, mental or emotional abuse or neglect or sexual abuse may report the matter as provided in subsection (c) or (e). (c) Except as provided by subsection (e), reports made pursuant to this section shall be made to the state department of social and rehabilitation services. When the department is not open for business, the reports shall be made to the appropriate law enforcement agency. On the next day that the state department of social and rehabilitation services is open for business, the law enforcement agency shall report to the department any report received and any investigation initiated pursuant to subsection (a) of K.S.A. 38-1524 and amendments thereto. The reports may be made orally or on request of the department in writing. (d) Any person who is required by this section to report an injury to a child and who knows of the death of a child shall notify immediately the coroner as provided by K.S.A.22a-242 and amendments thereto. (e) Reports of child abuse or neglect occurring in an institution operated by the secretary of social and rehabilitation services or the commissioner of juvenile justice shall be made to the attorney general. All other reports of child abuse or neglect by persons employed by or of children of persons employed by the state department of social and rehabilitation services or the juvenile justice authority shall be made to the appropriate law enforcement agency. (f) Willful and knowing failure to make a report required by this section is a class B misdemeanor. (g) Preventing or interfering with, the intent to prevent, the making of a report required by the section is a class B misdemeanor.

There are currently 15 different adverse incidents being captured in the AIR system including: Abuse, Fiduciary Abuse, Neglect, Death, Law Enforcement Involvement, Restraint, Elopement, Seclusion, ER/Hospitalization, Misuse of Medications, Serious Injury, Exploitation, Natural Disaster, Suicide, Suicide Attempt and "Other" Also, the reporter has the ability to select as many adverse incidents as may apply per that particular situation.

AIR is used to report adverse/critical incidents involving individuals receiving services by providers who are licensed by or contracted with KDADS including all HCBS waivers.

AIR reports are required to be submitted to KDADS w/in 24 hours of the individual becoming aware of the adverse incident.

Reporting entities/individuals may include (but are not limited to):

- All KDADS licensed providers
- Community Developmental Disability Organization (CDDO)
- Aging and Disability Resource Center (ADRC)
- Financial Management Services Providers (FMS)
- Community Mental Health Center (CMHC)
- Psychiatric Residential Treatment Facilities (PRTF)
- Substance Abuse Treatment Facilities
- Targeted Case Managers (TCM)
- Concerned community members (have the ability)

**c. Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities

when the participant may have experienced abuse, neglect or exploitation.

The participant's chosen KanCare MCO provides information and resources to all participants and caregivers regarding strategies to identify, prevent, report, and correct any instances of potential Abuse, Neglect or Exploitation. Information and training on these subjects is provided by the MCOs to members in the member handbook, is available for review at any time on the MCO member website, and is reviewed with each member, by the care management staff responsible for service plan development, during the annual process of plan of care/service plan development. Depending upon the individual needs of each member, additional training or information is made available and related needs are addressed in the individual's service plan. The information provided by the MCOs is consistent with the state's abuse, neglect and exploitation incident reporting and management process (although the MCOs also have additional incident management information and processes beyond those regarding reporting/management of member abuse, neglect and exploitation).

- d. Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

- The entity that receives reports of each type of critical event or incident: Kansas Department for Children and Families.

- The entity that is responsible for evaluating reports and how reports are evaluated.

Kansas Department for Children and Families (DCF) Intake Unit is responsible for receiving reports and determining if each report is screened in or out based on current policies identified in The Kansas Economic and Employment Support Manual [KEESM] for screening reports [12210]. If the report indicates criminal activity, local law enforcement is notified immediately.

- The timeframes for conducting an investigation and completing an investigation.

For children, the State of Kansas requires reporting of any suspected Abuse, Neglect, Exploitation or Fiduciary Abuse of a child to DCF for review and follow-up. If the report alleges that a child is not in immediate, serious, physical danger, but the report alleges critical neglect or physical/sexual abuse, DCF must respond within 72 hours. If the report alleges that a child is not in immediate, serious, physical danger and the report does not allege physical or sexual abuse or neglect, DCF must respond within 20 working days. By policy, Children and Family Services (CFS) is required to make a case finding in 25 working days from case assignment.

- The process and timeframes for informing the participant including the participant (or the participant's family or legal representative as appropriate) and other relevant parties (e.g., the waiver providers, licensing and regulatory authorities, the waiver operating agency) of the investigation results.

2540 Notice of Department Finding:

The Notice of Department Finding for family reports is CFS 2012. The Notice of Department Finding for facility reports is CFS 2013. The Notice of Department Finding informs pertinent persons who have a need to know of the outcome of an investigation of child abuse/neglect. The Notice of Department Finding also provides persons information regarding the appeal process. The following persons must receive a notice:

The parents of the child who was alleged to have been maltreated

The alleged perpetrator

Child, as applicable if the child lives separate from the family

Contractor providing services to the family if the family is receiving services from a CFS contract

The director of the facility or the child placing agency of a foster home if abuse occurred in a facility or foster home

Kansas Department of Health and Environment if abuse occurred in a facility or a foster home

The Notice of Department Finding shall be mailed on the same day, or the next working day, as the case finding decision, the date on the Case Finding CFS-2011.

All case decisions/findings shall be staffed with the APS Supervisor/designee and a finding shall be made within (30) working days of receiving the report [K.S.A. 39-1433(a)(3)].

KEESM [12360] allows for joint investigations with KDADS licensed facilities per the option of the DCF Service Center and the facility. Joint investigations require a Memorandum of Agreement between the DCF Service Center and the facility which must be approved by the DCF Central Office APS Attorney. Additionally, the KEESM manual [12230] requires copies of facility based reports be sent to the KDADS Regional Field Staff.

MCOs are granted access to the Adverse Incident Reporting (AIR) system. Critical events or incidents submitted to the AIR systems are available to MCOs as part of KDADS notification to the MCOs a critical event had occurred. KDADS quality team has primary responsibility for ensuring the incidents are reviewed and addressed. KDADS quality team will reach out to the MCOs when collaboration and joint effort in follow up is necessary in order to effectively remediate an event or incident.

There are three Program Integrity Compliance (PIC) Specialists who monitor what is called a "CSSPRC" mailbox as a way to have a view in to the Department for Children and Families (DCF) reporting system as they may correspond to any of our Adverse Incident Report (AIR) reports. Any substantiated report located in the mailbox is immediately forwarded on to the designated MCO personnel responsible for that particular beneficiary. Program Integrity staff also look to ensure if an AIR report also warrants an DCF report that those reports are being made. If not, PIC staff either follow up with the reporting party and ask them to make an DCF report, or (often times) the PIC staff will report the information to DCF themselves. The AIR system allows the reporter to reflect that an DCF report has been made. PIC staff keeps track of those reports and monitor to see the results of the DCF investigation via the mailbox. If there is a

specific case PIC staff are tracking the outcome of PIC staff will contact DCF. DCF provides the determination as well as any relative information. KDADS and DCF have a plan in place for DCF to automatically upload data in to the AIR system.

The appropriate MCO is notified of every AIR report as it may pertain to any of their beneficiaries. As each AIR report arrives at KDADS it is assigned to the appropriate KDADS staff by program and respective region. KDADS staff reviews the AIR report and verify the MCO against MMIS to ensure HIPAA compliance. Once this action has been completed, the AIR system is used to notify the MCO. An email notification is provided to the appropriate MCO. If the MCO does initiate any sort of action on non-abuse, neglect, or exploitation reports, they record the result of their outreach/investigation in their local systems as well as email KDADS staff any pertinent information that should be included back in the AIR system in attempt to gain closure.

All three MCOs follow up on ALL adverse incidents regardless of type of report or who else may be involved (DCF, KDADS licensing etc). Typically, the adverse incident type would dictate which entity is the primary entity responsible for the follow up. The below chart outlines which agency is responsible for following up on which types of adverse incidents:

Adverse Incident Type	Primary Entity for follow up
Abuse	DCF
Elopement	KDADS
Exploitation	DCF
Fiduciary Abuse	DCF
Law Enforcement Involvement	DCF
Natural Disaster	KDADS
Neglect	DCF
Seclusion	KDADS
Restraint	KDADS
Serious Injury	MCO
Misuse of Medications	MCO
ER/Hospitalization	MCO
Death	MCO
Suicide	MCO
Suicide Attempt	MCO
Other	KDADS

- e. Responsibility for Oversight of Critical Incidents and Events.** Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

- The state entity or entities responsible for overseeing the operation of the incident management system.

KDADS is the entity responsible for overseeing the operation of the incidence management system called Adverse Incidence Reporting (AIR) system. Kansas Department for Children and Families, Division of Child Protective Services is responsible for overseeing the reporting of and response to all critical incidents and events related to abuse, neglect and exploitation. Child Protective Services maintains a data base of all critical incidents/events and makes available the contents of the data base to the Kansas Department for Aging and Disability Services and the Kansas Department of Health and Environment, single state Medicaid agency, on an on-going basis.

- The methods for overseeing the operation of the (AIR) system, including how data are collected, compiled, and used to prevent re-occurrence.

The KDADS Quality Program Manager is responsible for reviewing the incidences reported to AIR and assigning incident to appropriate KDADS field staff for discovery, follow up and remediation. The Quality Program Manager and the DCF Child Protective Services Program Manager gather, trend and evaluate data from both sources and report the data to KDADS CSP Director and the State Medicaid Agency.

The KDADS quality team is responsible for reviewing reported critical incidents and events. The data is collected and compiled, trended by waiver population so that it can be analyzed to enable the identification of trends/patterns and the development of quality improvement/ remediation strategies to reduce future occurrence of critical incidents or events. This information will also be a monitoring, reporting and follow up element of the comprehensive KanCare quality improvement strategy, managed by an interagency monitoring team to support overall quality improvement activities for the KanCare program.

- The frequency of oversight activities.

KDADS conducts on-going, on-site, in-person reviews on a quarterly basis to educate and assess the participant's knowledge and ability and freedom to prevent or report information about Abuse, Neglect, and Exploitation. If it is determined that there is suspected for Abuse, Neglect or Exploitation, the KDADS Field Staff report immediately. Any areas of vulnerability would be identified for additional training and assurance of education.

MCOs are granted access to the Adverse Incident Reporting (AIR) system. Critical events or incidents submitted to the AIR systems are available to MCOs as part of KDADS notification to the MCOs a critical event had occurred. KDADS quality team has primary responsibility for ensuring the incidents are reviewed and addressed. KDADS quality team will reach out to the MCOs when collaboration and joint effort in follow up is necessary in order to effectively remediate an event or incident.

## Appendix G: Participant Safeguards

### Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

- a. Use of Restraints.** *(Select one): (For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

#### **The state does not permit or prohibits the use of restraints**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

**The use of restraints is permitted during the course of the delivery of waiver services.** Complete Items G-2-a-i and G-2-a-ii.

- i. Safeguards Concerning the Use of Restraints.** Specify the safeguards that the state has established

concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The need for this addition to the Autism Waiver was brought to the attention of the state based on stakeholder input. Stakeholders requested a policy to define appropriate restraint and seclusion requirements to ensure that the health and safety of the child are met in the event that the need arises. In the future, Kansas will ensure data is being collected.

Participants served shall have the right to be free from the unreasonable, unsafe, or unwarranted use of restraint for the purposes of discipline, punishment or staff/provider convenience. Service providers are expected to use positive behavioral support methods. If restraint is used as safety intervention, it should be the method of last resort. Restraints are not treatment interventions. It is inappropriate to use these methods instead of providing adequate levels of staff. If such methods are used for the purpose of behavior intervention, all such methods must follow the prescribed process. If the participant is known to have any medical condition such that restraint may endanger his/her health and safety, this process is prohibited.

1. The use of restraint is prohibited except:

- For an emergency;
- For the safety of the participant and/or others around him/her (imminent risk of harm) Imminent Risk of Harm – means an immediate and impending threat of causing substantial physical injury to self or others.

2. If by recorded history or recent event(s), it is determined that a participant is likely to have recurring behavioral episodes that puts the participant or others around him/her at risk of harm, then the participant's support team shall conduct the following:

- Functional Assessment of the behavior which includes clear data-based demonstration of other less restrictive behavior intervention strategies that have been implemented and proven ineffective.(Resources: KCART, KIPBS);
- Risk Assessment

3. If the decision is made to use restraint, it must be defined in the Plan of Care (POC) and include the items below:

- The topography;
- The function of the behavior;
- Where the restraint can occur or specifically how the restraint may occur;
- The maximum length of any period of restraint;
- The maximum number of times during a single day restraint may be used;
- As applicable, other conditions defined by the support team;
- Provider shall facilitate efforts to define alternative methods of behavior management to keep the situation from escalating to emergency status following any such episode (e.g. change environment, reduce exposure, redirect, change instruction, and provide visual supports);
- Specific data to be collected for each instance of restraint (e.g. frequency of behavior, additional conditions of behavior, steps/responses to behavior, procedural safeguards utilized), shall include number of times the restraint occurred within a fixed period of time;
- Frequency and criteria for notification to the care coordinator and the guardian;
- Date of review shall be within 30 calendar days of implementation of the POC to determine the effectiveness of and necessary adjustments to the restraint plan by the participant's designated team members to include parent/legal guardian and care coordinator. A team meeting may be convened at any time to review and possibly make changes in the use of intervention. Any plan developed by the team shall be signed by the participant's parent/legal guardian to document his/her approval. No plan shall be implemented with the participant's parent/legal guardian's consent.
- Following initial review, on-going review of restraint will be part of the POC review every 6 months or more often as deemed necessary by the designated team members.

4. When restraint is used, according to plan or emergency and as soon as possible after, the immediate staff and, if available, witnessing staff will document the use of the restraint, as follows.

- Description of the antecedents (e.g. environmental conditions, activity, who was working with the participant, other individuals in the area) immediately preceding the use;
- The specific behavior being addressed (e.g. number of occurrences, duration, description based on operational definition);
- The alternative strategies used to de-escalate the situation prior to use (e.g. sensory stimulation, choices,

redirect to preferred activity);

- How the restraint ended, including physical, medical and behavioral status of the participant (e.g. injuries, medical care provided, 10 seconds of calm and discontinuation of restraint);
- What happened after implementation of the restraint (e.g. participant demonstrated behavior again, participant left the room);
- From on-set of behavior to discontinuation of the restraint, staff reflect on and document the POC strategies they would implement again or they would use differently;
- Notify care coordinator, as identified in the POC.
- Notify parent/legal guardian, as identified in the POC.

5. During the period of restraint designated personnel must have the ability to see and hear the individual at all times.

6. Personal and/or Mechanical restraint should be appropriate to the severity of the child's behavior, size and physical strength/capabilities of the participant and the least restrictive strategy possible to reduce the likelihood of harm.

7. Personnel implementing restraint must be properly trained and knowledgeable of the following:

- Methods of safely escorting the participant;
- Methods for implementing the restraint;
- Supervision of the participant while in restraint;
- Understanding of rules governing restraint practices;
- Training is conducted within specific timelines of a nationally recognized, best practice training curriculum specific to restraint and should include, at a minimum:
  - Proper use of positive behavior supports, techniques and strategies designed to minimize and prevent the need for use of restraint;
  - Safe administration of restraint;
  - Physical safety during emergencies;
  - Identification of the effects of restraint on the participant restrained physical signs of distress and need for medical attention;
  - Simulated experience of administering and receiving restraint.
- Proof of appropriate training should be documented in providers file.

MCOs are granted access to the Adverse Incident Reporting (AIR) system. Critical events or incidents submitted to the AIR systems are available to MCOs as part of KDADS notification to the MCOs a critical event had occurred. KDADS quality team has primary responsibility for ensuring the incidents are reviewed and addressed. KDADS quality team will reach out to the MCOs when collaboration and joint effort in follow up is necessary in order to effectively remediate an event or incident. As part of ongoing monitoring the State has added two (2) sub-assurances in the QIS sub-section of Appendix G.

- ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:



- The Kansas Department for Aging and Disability Services (KDADS-CSP) has primary responsibility for overseeing this issue, and works with the Kansas Department of Health and Environment (KDHE), as part of the comprehensive KanCare quality improvement strategy to monitor this service issue. Information and findings are reported to KDHE through quarterly/annual reports during the Long Term Care Committee Meeting.

- Methods for detecting unauthorized use, over use or inappropriate, ineffective use of restrictive interventions and ensuring that all applicable state requirements are followed.

KDADS conducts on-going, on-site, in-person reviews to educate and assess the participant's knowledge, ability and freedom from the use of restraints. If it is determined that there is suspected un-authorized use, the KDADS Field Staff report immediately to the Quality Program Manager and the appropriate abuse hotline. Immediate remediation would follow the reporting. Quality field staff will be responsible for ensuring these issues are effectively in place for waiver participants, as part of the overall KanCare quality improvement strategy.

- How data are analyzed to identify trends and patterns and support improvement strategies; and the methods for overseeing the operation of the incident management system including how data are collected, compiled, and used to prevent re-occurrence.

KDADS Field Staff conduct on-going, record review and on-site, in-person interviews with the participant and his/her informal supports and paid staff supports to ensure there is no use of unauthorized restraint. KDADS Field staff review planning for each individual to ensure appropriate supports and services are in place to eliminate the need for restraints.

The following Performance Improvement Analysis Process occurs on an annual basis.

1. Data Aggregation is completed by the data analysis staff.
2. Performance Improvement Analysis Process including:
  - a. Performance Improvement Team including the Program Manager, Quality and TCM program Manager, data analysis staff and QMS staff reviews the data for trends and determines the necessity of changes to the tool, training or program might be necessary.
3. Performance Improvement Waiver Report provided to KDHE via the KDHE Long Term Care Committee, for review by the State Medicaid Agency (SSMA).

- The methods for overseeing the operation of the incident management system including how data are collected, compiled, and used to prevent re-occurrence.

Oversight for compliance to assure the protection of children, regulatory standards, and statute is conducted by KDADS-CSP Field Staff (QMS) through on-going, on-site record review, observation, interviews of individuals served, guardians if applicable, and staff, review of compliance of the individual's plan of care (POC). KDADS-CSP (QMS) Field Staff are responsible for addressing all unauthorized restraint with the service provider to ensure preventative action is taken for the protection of children.

Data gathered by KDADS-CSP Field Staff during the Quality Review Process is provided quarterly to the KDADS-CSP Performance Improvement team chaired by the Quality Program Manager, for evaluation and trending to identify areas for improvement. Upon completion of identified areas of improvement this information is compiled into an executive report (quarterly and annually) which is submitted to the Performance Improvement Executive Committee Chaired by the Assistant Director KDADS-CSP, staffed by HCBS Program Managers, QA Program Manager. The Performance Improvement Committee generates corrective action planning and improvement planning which is submitted to the Director of KDADS-CSP, the Medicaid Operating Agency, for review and approval or denial and sent to the KDHE via the KDHE Long Term Care Committee for review by the State Medicaid Agency (SSMA). The approval or denial from the Director of KDADS-CSP would be returned to the Performance Improvement team for corrective action or planning for implementation of improvement.

- The frequency of oversight: Continuous and ongoing.

## Appendix G: Participant Safeguards

### Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

**b. Use of Restrictive Interventions.** *(Select one):***The state does not permit or prohibits the use of restrictive interventions**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

The State has added 2 sub-assurances under the QIS sub-section of Appendix G to ensure ongoing monitoring and oversight of unauthorized uses of restrictive interventions. The sub-assurances added were developed to be consistent with global reporting measures that the State developed with the assistance of CMS and Truven through technical assistance to bring quality reporting into the managed care environment in 2014.

The State will be utilizing the AIR system to monitor all restrictive interventions as well as any adverse incidents.

**The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

- i. Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

- ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

## Appendix G: Participant Safeguards

### Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

- c. Use of Seclusion.** *(Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

**The state does not permit or prohibits the use of seclusion**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

**The use of seclusion is permitted during the course of the delivery of waiver services.** Complete Items G-2-c-i and G-2-c-ii.

- i. Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).



Participants served shall have the right to be free from the unreasonable, unsafe, or unwarranted use of seclusion for the purposes of discipline, punishment or staff/provider convenience. Service providers are expected to use positive behavioral support methods. If seclusion is used as safety intervention, it should be the method of last resort. Seclusion is not treatment interventions. It is inappropriate to use these methods instead of providing adequate levels of staff. If such methods are used for the purpose of behavior intervention, all such methods must follow the prescribed process. If the participant is known to have any medical condition such that seclusion may endanger his/her health and safety, this process is prohibited.

2. If by recorded history or recent event(s), it is determined that a participant is likely to have recurring behavioral episodes that puts the participant or others around him/her at risk of harm, then the participant's support team shall conduct the following:

- Functional Assessment of the behavior which includes clear data-based demonstration of other less restrictive behavior intervention strategies that have been implemented and proven ineffective.(Resources: KCART, KIPBS);
- Risk Assessment

3. If the decision is made to use seclusion, it must be defined in the Plan of Care (POC) and include the items below:

- The topography;
- The function of the behavior;
- Where the seclusion can occur or specifically how the seclusion may occur;
- The maximum length of any period of seclusion;
- The maximum number of times during a single day seclusion may be used;
- As applicable, other conditions defined by the support team;
- Provider shall facilitate efforts to define alternative methods of behavior management to keep the situation from escalating to emergency status following any such episode (e.g. change environment, reduce exposure, redirect, change instruction, and provide visual supports);
- Specific data to be collected for each instance of seclusion (e.g. frequency of behavior, additional conditions of behavior, steps/responses to behavior, procedural safeguards utilized), shall include number of times the seclusion occurred within a fixed period of time;
- Frequency and criteria for notification to the care coordinator and the guardian;
- Date of review shall be within 30 calendar days of implementation of the POC to determine the effectiveness of and necessary adjustments to the seclusion plan by the participant's designated team members to include parent/legal guardian and care coordinator. A team meeting may be convened at any time to review and possibly make changes in the use of intervention. Any plan developed by the team shall be signed by the participant's parent/legal guardian to document his/her approval. No plan shall be implemented without the participant's parent/legal guardian's consent.
- Following initial review, on-going review of seclusion will be part of the POC review every 6 months or more often as deemed necessary by the designated team members.

4. When seclusion is used, according to plan or emergency and as soon as possible after, the immediate staff and, if available, witnessing staff will document the use of the seclusion, as follows.

- Description of the antecedents (e.g. environmental conditions, activity, who was working with the participant, other individuals in the area) immediately preceding the use;
- The specific behavior being addressed (e.g. number of occurrences, duration, description based on operational definition);
- The alternative strategies used to de-escalate the situation prior to use (e.g. sensory stimulation, choices, redirect to preferred activity);
- How the seclusion ended, including physical, medical and behavioral status of the participant (e.g. injuries, medical care provided, 10 seconds of calm and discontinuation of seclusion);
- What happened after implementation of the seclusion (e.g. participant demonstrated behavior again, participant left the room);
- From on-set of behavior to discontinuation of the, staff reflect on and document the Plan of Care strategies they would implement again or they would use differently;
- Notify care coordinator, as identified in the Plan of Care;
- Notify parent/legal guardian, as identified in the Plan of Care.

5. During the period of seclusion designated personnel must have the ability to see and hear the individual at all times.
6. No more than one individual at a time may be placed within one seclusion space.
7. Designated Seclusion Rooms must provide room for the participant to lie down, stand and move. Any area utilized for seclusion must meet the following specifications:
  - At least 36 square feet;
  - Equipped with heating, cooling, ventilation and lighting comparable to remainder of building;
  - Free of objects that pose a danger;
  - Equipped with a door that locks only if the lock automatically disengages when a person on the exterior of the door moves away.
9. Personnel implementing seclusion must be properly trained and knowledgeable of the following:
  - Methods of safely escorting the participant;
  - Methods for implementing seclusion;
  - Supervision of the participant while in seclusion;
  - Understanding of rules governing seclusion practices;
  - Training is conducted within specific timelines of a nationally recognized, best practice training curriculum specific to seclusion and should include, at a minimum:
    - Proper use of positive behavior supports, techniques and strategies designed to minimize and prevent the need for use of seclusion;
    - Safe administration of seclusion;
    - Physical safety during emergencies;
    - Identification of the effects of seclusion on the participant seclusion, physical signs of distress and need for medical attention;
    - Simulated experience of administering and receiving seclusion.
    - Proof of appropriate training should be documented in providers file.

**ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

The Kansas Department for Aging and Disability Services (KDADS-CSP) has primary responsibility for overseeing this issue, and works with the Kansas Department of Health and Environment (KDHE), as part of the comprehensive KanCare quality improvement strategy to monitor this service issue. Information and findings are reported to KDHE through quarterly/annual reports during the Long Term Care Committee Meeting.

- Methods for detecting unauthorized use, over use or inappropriate, ineffective use of restrictive interventions and ensuring that all applicable state requirements are followed.

KDADS conducts on-going, on-site, in-person reviews to educate and assess the participant's knowledge, ability and freedom from the use of seclusion. If it is determined that there is suspected un-authorized use, the KDADS Field Staff report immediately to the Quality Program Manager and the appropriate abuse hotline. Immediate remediation would follow the reporting. Quality field staff will be responsible for ensuring these issues are effectively in place for waiver participants, as part of the overall KanCare quality improvement strategy.

- How data are analyzed to identify trends and patterns and support improvement strategies; and the methods for overseeing the operation of the incident management system including how data are collected, compiled, and used to prevent re-occurrence.

KDADS Field Staff conduct on-going, record review and on-site, in-person interviews with the participant and his/her informal supports and paid staff supports to ensure there is no use of unauthorized seclusion. KDADS Field staff review planning for each individual to ensure appropriate supports and services are in place to eliminate the need for seclusion.

The following Performance Improvement Analysis Process occurs on an annual basis.

1. Data Aggregation is completed by the data analysis staff.
2. Performance Improvement Analysis Process including:
  - a. Performance Improvement Team including the Program Manager, Quality and TCM program Manager, data analysis staff and QMS staff reviews the data for trends and determines the necessity of changes to the tool, training or program might be necessary.
3. Performance Improvement Waiver Report provided to KDHE via the KDHE Long Term Care Committee, for review by the State Medicaid Agency (SSMA).

- The methods for overseeing the operation of the incident management system including how data are collected, compiled, and used to prevent re-occurrence.

Oversight for compliance to assure the protection of children, regulatory standards, and statute is conducted by KDADS-CSP Field Staff (QMS) through on-going, on-site record review, observation, interviews of individuals served, guardians if applicable, and staff, review of compliance of the individual's Person-Centered Support Plan. KDADS-CSP (QMS) Field Staff are responsible for addressing all unauthorized seclusion with the service provider to ensure preventative action is taken for the protection of children.

Data gathered by KDADS-CSP Field Staff during the Quality Review Process is provided quarterly to the KDADS-CSP Performance Improvement team chaired by the Quality Program Manager, for evaluation and trending to identify areas for improvement. Upon completion of identified areas of improvement this information is compiled into an executive report (quarterly and annually) which is submitted to the Performance Improvement Executive Committee Chaired by the Assistant Director KDADS-CSP, staffed by HCBS Program Managers, QA Program Manager. The Performance Improvement Committee generates corrective action planning and improvement planning which is submitted to the Director of KDADS-CSP, the Medicaid Operating Agency, for review and approval or denial and sent to the KDHE via the KDHE Long Term Care Committee for review by the State Medicaid Agency (SSMA). The approval or denial from the Director of KDADS-CSP would be returned to the Performance Improvement team for corrective action or planning for implementation of improvement.

- The frequency of oversight: Continuous and ongoing.

## Appendix G: Participant Safeguards

### Appendix G-3: Medication Management and Administration (1 of 2)

*This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix*

*does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.*

**a. Applicability.** Select one:

**No. This Appendix is not applicable** *(do not complete the remaining items)*

**Yes. This Appendix applies** *(complete the remaining items)*

**b. Medication Management and Follow-Up**

- i. Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

- ii. Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

## Appendix G: Participant Safeguards

### Appendix G-3: Medication Management and Administration (2 of 2)

**c. Medication Administration by Waiver Providers**

**Answers provided in G-3-a indicate you do not need to complete this section**

- i. Provider Administration of Medications.** *Select one:*

**Not applicable.** *(do not complete the remaining items)*

**Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

- ii. State Policy.** Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

- iii. Medication Error Reporting.** *Select one of the following:*

**Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**

*Complete the following three items:*

- (a) Specify state agency (or agencies) to which errors are reported:

(b) Specify the types of medication errors that providers are required to *record*:

(c) Specify the types of medication errors that providers must *report* to the state:

**Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.**

Specify the types of medication errors that providers are required to record:

**iv. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

## Appendix G: Participant Safeguards

### Quality Improvement: Health and Welfare

*As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.*

#### **a. Methods for Discovery: Health and Welfare**

***The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. (For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")***

##### **i. Sub-Assurances:**

**a. Sub-assurance:** *The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death. (Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

##### **Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to*



analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

**Performance Measure:**

**Number and percent of unexpected deaths for which the appropriate follow-up measures were taken** N=Number of unexpected deaths for which the appropriate follow-up measures were taken as in the approved waiver D=Number of unexpected deaths

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Record reviews**

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
<b>Other</b> Specify: <div style="border: 1px solid black; padding: 2px;">Managed Care Organizations (MCOs)</div>	<b>Annually</b>	<b>Stratified</b> Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:  <div style="border: 1px solid black; padding: 5px; width: fit-content;"> KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency </div>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:  <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

**Performance Measure:**

**Number and percent of unexpected deaths for which review/investigation followed the appropriate policies and procedures** N=Number of unexpected deaths for which review/investigation followed the appropriate policies and procedures as in the approved waiver D=Number of unexpected deaths

**Data Source (Select one):****Other**

If 'Other' is selected, specify:  
**record review**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval =

		<input type="text"/>
<b>Other</b> Specify:  <div>Managed Care Organizations (MCOs)</div>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  <input type="text"/>
	<b>Other</b> Specify:  <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:  <div>KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency</div>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:  <input type="text"/>

**Performance Measure:**

**Number and percent of waiver participants who received information on how to report suspected abuse, neglect, or exploitation**  
**N=Number of waiver participants who received information on how to report suspected abuse, neglect, or exploitation**  
**D=Number of waiver participants interviewed by QMS staff or whose records are reviewed**

**Data Source** (Select one):

**Presentation of policies or procedures**

If 'Other' is selected, specify:

**Records reviews and customer interviews**

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <div>95%</div>
<b>Other</b> Specify: <div>Managed Care Organizations (MCOs)</div>	<b>Annually</b>	<b>Stratified</b> Describe Group: <div>Proportionate by MCO</div>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <div></div>
	<b>Other</b> Specify: <div></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency </div>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <div style="border: 1px solid black; height: 30px; margin-top: 10px;"></div>

**Performance Measure:**

**Number and percent of unexpected deaths for which review/investigation resulted in the identification of preventable causes**  $N = \text{Number of unexpected deaths for which review/investigation resulted in the identification of non-preventable causes}$   
 $D = \text{Number of unexpected deaths}$

**Data Source** (Select one):**Other**

If 'Other' is selected, specify:

**Record reviews**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval =

		<input type="text"/>
<b>Other</b> Specify:  <div>Managed Care Organizations (MCOs)</div>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  <input type="text"/>
	<b>Other</b> Specify:  <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:  <div>KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency</div>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:  <input type="text"/>

- b. Sub-assurance:** *The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.*

### Performance Measures

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

### Performance Measure:

**Number and percent of participants' reported critical incidents that were initiated and reviewed within required time frames**  
 $N = \text{Number of participants' reported critical incidents that were initiated and reviewed within required time frames as specified in the approved waiver}$   
 $D = \text{Number of participants' reported critical incidents}$

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Critical incident management system**

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text"/>
<b>Other</b> Specify:  <input type="text" value="Managed Care Organizations (MCOs)"/>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:

		<input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**Number and percent of reported critical incidents requiring review/investigation where the State adhered to its follow-up measures**  
**N=Number of reported critical incidents requiring review/investigation where the State adhered to the follow-up methods as specified in the approved waiver**  
**D=Number of reported critical incidents**

**Data Source** (Select one):**Other**

If 'Other' is selected, specify:

**Critical incident management system**

<b>Responsible Party for data collection/generation</b>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
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<i>(check each that applies):</i>		
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100px; margin-top: 5px;"></div>
<b>Other</b> Specify: <div style="border: 1px solid black; padding: 5px; margin-top: 5px;">Managed Care Organizations (MCOs)</div>	<b>Annually</b>	<b>Stratified</b> Describe Group: <div style="border: 1px solid black; height: 20px; width: 100px; margin-top: 5px;"></div>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100px; margin-top: 5px;"></div>
	<b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100px; margin-top: 5px;"></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:	<b>Annually</b>

<b>Responsible Party for data aggregation and analysis</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency	
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

- c. *Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.*

#### Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

#### Performance Measure:

**Number and percent of restraint applications, seclusion or other restrictive interventions that followed procedures as specified in the approved waiver.**

**N=Number of restraint applications, seclusion or other restrictive interventions that followed procedures as specified in the approved waiver. D=Number of restraint applications, seclusion or other restrictive interventions**

**Data Source** (Select one):

**Critical events and incident reports**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b>

		Confidence Interval =  <div>Proportionate Sample, 95% confidence interval.</div>
<b>Other</b> Specify:  <div>MCO/Providers</div>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <div>Stratified by MCO</div>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  <div></div>
	<b>Other</b> Specify:  <div>The State Operating Agency maintains the AIR system. Reports are made via an online reporting application. During the quarterly reviews a report will be ran which captures numerator and denominator.</div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:	<b>Annually</b>

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
MCO	
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: 

**Performance Measure:**

**Number and percent of unauthorized uses of restrictive interventions that were appropriately reported. N=Number of unauthorized uses of restrictive interventions that were appropriately reported. D=Number of unauthorized uses of restrictive interventions.**

**Data Source** (Select one):**Critical events and incident reports**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval =  Representative Proportionate Sample, 95% confidence interval
<b>Other</b> Specify: MCO's/Providers	<b>Annually</b>	<b>Stratified</b> Describe Group:  Stratified by the MCO.
	<b>Continuously and</b>	<b>Other</b>

	<b>Ongoing</b>	Specify:  
	<b>Other</b> Specify:  <div style="border: 1px solid black; padding: 5px;"> The State Operating Agency maintains the AIR system. Reports are made via an online reporting application. During the quarterly reviews a report will be ran which captures numerator and denominator. </div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:  <div style="border: 1px solid black; padding: 5px;"> MCO's </div>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:  <div style="border: 1px solid black; height: 30px;"></div>

**d. Sub-assurance:** *The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.*

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**

**Number and percent of waiver participants who have a disaster red flag designation with a related disaster backup plan N=Number of waiver participants who have a disaster red flag designation with a related disaster backup plan D=Number of waiver participants with a red flag designation**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Record reviews**

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <div style="border: 1px solid black; padding: 2px; width: 100px; margin-top: 5px;">95%</div>
<b>Other</b> Specify: <div style="border: 1px solid black; padding: 2px; width: 100px; margin-top: 5px;">Managed Care Organizations</div>	<b>Annually</b>	<b>Stratified</b> Describe Group: <div style="border: 1px solid black; padding: 2px; width: 100px; margin-top: 5px;"></div>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <div style="border: 1px solid black; padding: 2px; width: 100px; margin-top: 5px;"></div>
	<b>Other</b> Specify:	

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**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:  <div style="border: 1px solid black; padding: 5px; width: fit-content;"> KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency </div>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:  <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

**Performance Measure:**

**Number and percent of waiver participants who received physical exams in accordance with State policies, N=Number of HCBS participants who received physical exams in accordance with State policies,D= Number of HCBS participants whose service plans were reviewed**

**Data Source** (Select one):**Other**

If 'Other' is selected, specify:

**Record reviews**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>

<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <div>95%</div>
<b>Other</b> Specify: <div>Managed Care Organizations (MCOs)</div>	<b>Annually</b>	<b>Stratified</b> Describe Group: <div></div>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <div></div>
	<b>Other</b> Specify: <div></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <div>KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency</div>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:



Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	<div data-bbox="868 271 1262 353" style="border: 1px solid black; height: 37px; width: 247px;"></div>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Collaboration between the KDADS Field Staff and DCF-CPS Social Worker occurs on an on-going basis to review trends and severity of Critical Events. KDADS Field Staff identify trends and severity with Autism waiver providers to ensure adequate services and supports are in place. Additionally, KDADS conducts on-going, on-site, in-person reviews to educate and assess the participant's knowledge and ability and freedom to prevent or report information about Abuse, Neglect, and Exploitation. If it is determined that there is suspected Abuse, Neglect or Exploitation, the KDADS Field Staff report immediately. Any areas of vulnerability would be identified for additional training and assurance of education.

DCF's Division of Child Protective Services is responsible for overseeing the reporting of and response to all critical incidents and events. Child Protective Services maintains a data base of all critical incidents/events and makes available the contents of the data base to the KDADS and KDHE on an on-going basis. The Performance Improvement Program Manager of KDADS-Community Services and Programs, and the DCF Child Protective Services Program Manager, and Children and Family Services gather, trend and evaluate data from multiple sources that is reported to the KDADS-Community Services and Programs Director and the State Medicaid Agency.

These measures and collection/reporting protocols, together with others that are part of the KanCare MCO contract, are included in a statewide comprehensive KanCare quality improvement strategy which is regularly reviewed and adjusted. (The QIS is reviewed at least annually, and adjusted as necessary based upon that review.) That plan is contributed to and monitored through a state interagency monitoring team, which includes program managers, fiscal staff and other relevant staff/resources from both the state Medicaid agency and the state operating agency.

#### **b. Methods for Remediation/Fixing Individual Problems**

- i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

KDADS-Community Services & Programs is responsible for oversight of critical events/incidents, and unauthorized use of restraints/restrictive procedures, in accordance with Kansas regulatory and statutory requirements. Oversight of regulatory standards and statute is conducted by KDADS Field Staff.

DCF-Child Protective Services (CPS) and DCF-Child Protective Services (APS) maintain data bases of all critical incidents and events. CPS and APS maintain data bases of all critical incidents and events and make available the contents of the data base to KDADS and KDHE through quarterly reporting.

KDADS and DCF-Child Protective Services (CPS) and DCF-Child Protective Services (APS) meet on a quarterly basis to trend data, develop evidence-based decisions, and identify opportunities for provider improvement and/or training.

State staff request, approve, and assure implementation of contractor corrective action planning and/or technical assistance to address non-compliance with performance standards as detected through on-site monitoring, MCO compliance monitoring, survey results and other performance monitoring. These processes are monitored by both contract managers and other relevant state staff, depending upon the type of issue involved, and results tracked consistent with the statewide quality improvement strategy and the operating protocols of the Interagency Monitoring Team.

## ii. Remediation Data Aggregation

### Remediation-related Data Aggregation and Analysis (including trend identification)

<b>Responsible Party</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:  <div>KanCare Managed Care Organizations (MCOs)</div>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:  <div></div>

## c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

**No**

**Yes**

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Kansas works with the Autism Advisory Group to finalize any development of this policy and Kansas intends to incorporate the below performance measures at the time of the next amendment/ renewal, whichever comes first. The following performance measures will be added:

- 1) Number and percent of restraint applications, seclusion or other restrictive interventions that followed procedures as specified in the approved waiver N=Number of restraint applications, seclusion or other restrictive interventions that followed procedures as specified in the approved waiver D=Number of restraint applications, seclusion or other restrictive interventions
- 2) Number and percent of unauthorized uses of restrictive interventions that were appropriately reported N=Number of unauthorized uses of restrictive interventions that were appropriately reported D=Number of unauthorized uses of restrictive interventions

## Appendix H: Quality Improvement Strategy (1 of 3)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

### Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the

Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

## **Appendix H: Quality Improvement Strategy (2 of 3)**

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### **H-1: Systems Improvement**

#### **a. System Improvements**

- i.** Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The Kansas Department of Health and Environment (KDHE), specifically the Division of Health Care Finance, operates as the single State Medicaid Agency, and the Kansas Department for Aging and Disability Services (KDADS) serve as the operating agency. The two agencies collaborate in developing operating agency priorities to meet established HCBS assurances and minimum standards of service.

Through KDADS's Quality Review (QR) process, a statistically significant random sample of HCBS participants is interviewed and data collected for meaningful participant feedback on the HCBS program. KDADS reviews a statistically significant sample of participants for the Autism (KS.0476) population and the other affected waiver populations under the Quality Improvement Strategy. These include the, Frail Elderly (KS.0303), Physical Disability (KS.304) waiver, Serious Emotional Disturbance (KS.0320), Traumatic Brain Injury (KS.4164) and Technology Assisted (KS.4165) waiver populations. The sampling will be done for each waiver individually as will all of the data aggregation, analysis and reporting.

The QR process includes review of participant case files against a standard protocol to ensure policy compliance. KDADS Program Managers regularly communicate with Managed Care Organizations, (MCOs), the functional eligibility contractor and HCBS service providers, thereby ensuring continual guidance on the HCBS service delivery system.

KDADS Quality Review staff collects data based on participant interviews and case file reviews. KDADS Program Evaluation staff reviews, compiles, and analyzes the data obtained as part of the Quality Review process at both the statewide and MCO levels to initiate the HCBS Quality Improvement process. This information is provided quarterly and annually to KDADS management, KDHE's Long-Term Care Committee and the interagency monitoring team and the KanCare Managed Care Organizations and contracted assessor organizations. De-identified results, to exclude any personally-identifying information, are available upon request to other interested parties. In addition to data captured through the QR process, other data is captured within the various State systems, the functional eligibility contractor's systems as well as the Managed Care Organizations' systems. On a routine basis, KDADS' Program Evaluation staff extracts or obtains data from the various systems and aggregates it, evaluating it for any trends or discrepancies as well as any systemic issues. Examples include, but are not limited to, reports focusing on qualified assessors and claims data.

A third major area of data collection and aggregation focuses on the agency's critical incident management system. KDADS worked with Child Protective Services (APS), a division within the Kansas Department for Children and Families (formerly the Kansas Department of Social and Rehabilitation Services) and the Managed Care Organizations and established a formal process for oversight of critical incidents and events, including reports generated for trending, the frequency of those reports, as well as how this information is communicated to DHCF-KDHE, the single state Medicaid agency. The system allows for uniform reporting and prevents any possible duplication of reporting to both the MCOs and the State. The Adverse Incident Reporting System, also known as AIR, facilitates ongoing quality improvement to ensure the health and safety of individuals receiving services by agencies or organizations licensed or funded by KDADS and provides information to improve policies, procedures and practices. Incidents are reported within 24 hours of providers becoming aware of the occurrence of the adverse incident. Examples of adverse incidents reported in the system include, but are not limited to, unexpected deaths, medication misuse, abuse, neglect and exploitation.

For all three main areas of data collection and aggregation, KDADS' Program Evaluation staff collects data, aggregates it, analyzes it and provides information regarding discrepancies and trends to Program staff, Quality Review staff and other management staff. If systemic issues are found, several different remediation strategies are utilized, depending upon the nature, scope and severity of the issues. Strategies include, but are not limited to, training of the QR staff to ensure the protocols are utilized correctly, protocol revisions to capture the appropriate data and policy clarifications to MCOs to ensure adherence to policy. Additionally, any remediation efforts might be MCO-specific or provider-specific, again depending on the nature, scope and severity of the issue(s).

## ii. System Improvement Activities

<b>Responsible Party</b> ( <i>check each that applies</i> ):	<b>Frequency of Monitoring and Analysis</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>

<b>Responsible Party</b> <i>(check each that applies):</i>	<b>Frequency of Monitoring and Analysis</b> <i>(check each that applies):</i>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Quality Improvement Committee</b>	<b>Annually</b>
<b>Other</b> Specify: <div>KanCare Managed Care Organizations (MCOs)</div>	<b>Other</b> Specify: <div></div>

### b. System Design Changes

- i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

The Kansas Department on Aging (KDADS) and the Division of Health Care Finance within the Kansas Department of Health and Environment monitor and analyze the effectiveness of system design changes using several methods, dependent on the system enhancement being implemented. System changes having a direct impact on HCBS participants are monitored and analyzed through KDADS's Quality Review process. Additional questions may be added to the HCBS Customer Interview Protocols to obtain participant feedback, or additional performance indicators and policy standards may be added to the HCBS Case File Quality Review Protocols. Results of these changes are collected, compiled, reviewed, and analyzed quarterly and annually.

Based on information gathered through the analysis of the Quality Review data and daily program administration, KDADS Program Managers determine if the issues are systemic or an isolated instance or issue. This information is reviewed to determine if training to a specific Managed Care Organization is sufficient, or if a system change is required.

The Kansas Assessment Management Information System (KAMIS) is the official electronic repository of data about KDADS customers and their received services. This customer-based data is used by KDADS and the MCOs to coordinate activities and manage HCBS programs. System changes are made to KAMIS to enhance the availability of information on participants and performance. Improvements to the KAMIS system are initiated through comments from stakeholders, KDADS Program Managers, and Quality Review staff, and approved and prioritized by KDADS management. Effectiveness of the system design change is monitored by KDADS's Program Managers, working in concert with KDADS's Quality Review and Program Evaluation staff.

DHCF-KDHE contracts with Hewlett Packard (HP) to manage the Medicaid Management Information System (MMIS). Improvements to this system require DHCF-KDHE approval of the concept and prioritization of the change. KDADS staff work with DHCF-KDHE and HP staff to generate recommended systems changes, which are then monitored and analyzed by HP and KDADS to ensure the system change operates as intended and meets the desired performance outcome.

- ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

Following is the process KDADS will use to identify and implement Quality Improvements and periodically evaluate the state's Quality Improvement Strategy:

**WORK PLAN:**

The Operating Agency has convened an internal HCBS Quality Improvement Committee, comprised of Program, Quality Review, and Program Evaluation Staff as of 1/18/2017. The group will meet quarterly to evaluate trends reflected in the HCBS Quality Review Reports and identify areas for improvement.

## Appendix H: Quality Improvement Strategy (3 of 3)

### H-2: Use of a Patient Experience of Care/Quality of Life Survey

**a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months (*Select one*):**

No

Yes (*Complete item H.2b*)

**b. Specify the type of survey tool the state uses:**

HCBS CAHPS Survey :

NCI Survey :

NCI AD Survey :

Other (*Please provide a description of the survey tool used*):

## Appendix I: Financial Accountability

### I-1: Financial Integrity and Accountability

**Financial Integrity.** Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Based on signed provider agreements, each HCBS provider is required to permit the Kansas Department of Health and Environment, the Kansas Department for Aging and Disabilities (KDADS), their designee, or any other governmental agency acting in its official capacity to examine any records and documents that are necessary to ascertain information pertinent to the determination of the proper amount of a payment due from the Medicaid program. Additionally, the Division of Legislative Post Audit contracts with an independent accounting firm to complete Kansas' statewide single audit on an annual basis. The accounting firm must comply with all requirements contained in the single audit act. The Medicaid program, including all home and community based services waivers is a required component of the single state audit. Independent audits of the waiver will look at cost-effectiveness, the quality of services, service access, and the substantiation of claims for HCBS payments. These issues are addressed in a variety of ways, including: statewide single annual audit; annual financial and other audits of the KanCare MCOs; encounter data, quality of care and other performance reviews/audits; and audits conducted on HCBS providers. There are business practices of the state that result in additional ongoing audit activities that provide infrastructure/safeguards for the HCBS programs, including:

- a. Because of other business relationships with the state, each of the following HCBS provider entities are required to obtain and submit annual financial audits, which are reviewed and used to inform their Medicaid business with Kansas: Area Agencies on Aging; Community Mental Health Centers; Community Developmental Disability Organizations; and Centers for Independent Living.
- b. As a core provider requirement, FMS providers must obtain and submit annual financial audits, which are reviewed and used to monitor their Medicaid business with Kansas.

Under the KanCare program, payment for services is being made through the monthly pmpm paid by the state to the contracting MCOs. (The MCOs make payments to individual providers, who are part of their networks and subject to contracting protections/reviews/member safeguards.) Payments to MCOs are subject to ongoing monitoring and reporting to CMS, consistent with the Special Terms and Conditions issued with approval of the related 1115 waiver. Those STCs include both monitoring of budget neutrality as well as general financial requirements, and also a robust evaluation of that demonstration project which addresses the impact of the KanCare program on access to care, the quality, efficiency, and coordination of care, and the cost of care.

In addition, these services - as part of the comprehensive KanCare managed care program - will be part of the corporate compliance/program integrity activities of each of the KanCare MCOs. That includes both monitoring and enforcement of their provider agreements with each provider member of their network and also a robust treatment, consistent with federal regulation and state law requirements, of prevention, detection, intervention, reporting, correction and remediation program related to fraud, waste, abuse or other impropriety in the delivery of Medicaid services under the KanCare program. The activities include comprehensive utilization management, quality data reporting and monitoring, and a compliance officer dedicated to the KanCare program, with a compliance committee that has access to MCO senior management. As those activities are implemented and outcomes achieved, the MCOs will be providing regular and ad hoc reporting of results. KDHE will have oversight of all portions of the program and the KanCare MCO contracts, and will collaborate with KDADS regarding HCBS program management, including those items that touch on financial integrity and corporate compliance/program integrity. The key component of that collaboration will be through the interagency monitoring team, an important part of the overall state's KanCare Quality Improvement Strategy, which will provide quality review and monitoring of all aspects of the KanCare program – engaging program management, contract management, and financial management staff from both KDHE and KDADS.

Some of the specific contractual requirements associated with the program integrity efforts of each MCO include:

#### *Coordination of Program Integrity Efforts.*

The CONTRACTOR shall coordinate any and all program integrity efforts with KDHE/DHCF personnel and Kansas' Medicaid Fraud Control Unit (MFCU), located within the Kansas Attorney General's Office. At a minimum, the CONTRACTOR shall:

- a. Meet monthly, and as required, with the KDHE/DHCF staff and MFCU staff to coordinate reporting of all instances of credible allegations of fraud, as well as all recoupment actions taken against providers;
- b. Provide any and all documentation or information upon request to KDHE/DHCF or MFCU related to any aspect of this contract, including but not limited to policies, procedures, subcontracts, provider agreements, claims data, encounter data, and reports on recoupment actions and receivables;
- c. Report within two (2) working days to the KDHE/DHCF, MFCU, and any appropriate legal authorities any evidence indicating the possibility of fraud and abuse by any member of the provider network; if the CONTRACTOR fails to report any suspected fraud or abuse, the State may invoke any penalties allowed under this contract including, but not limited to, suspension of payments or termination of the contract. Furthermore, the enforcement of penalties under the contract shall not be construed to bar other legal or equitable remedies which may be available to the State or MFCU for noncompliance with this section;



d. Provide KDHE/DHCF with a quarterly update of investigative activity, including corrective actions taken;

e. Hire and maintain a staff person in Kansas whose duties shall be composed at least 90% of the time in the oversight and management of the program integrity efforts required under this contract. This person shall be designated as the Program Integrity Manager. The program integrity manager shall have open and immediate access to all claims, claims processing data and any other electronic or paper information required to assure that program integrity activity of the CONTRACTOR is sufficient to meet the requirements of the KDHE/DHCF. The duties shall include, but not be limited to the following:

- (1) Oversight of the program integrity functions under this contract;
- (2) Liaison with the State in all matters regarding program integrity;
- (3) Development and operations of a fraud control program within the CONTRACTOR claims payment system;
- (4) Liaison with Kansas' MFCU;
- (5) Assure coordination of efforts with KDHE/DHCF and other agencies concerning program integrity issues.

The State operating agency Quality Assurance conduct annual MCO reviews and audits which are inclusive of HCBS services.

All providers are subject to 100% review annually by the State operating agency Quality Assurance staff.

100% of Autism waiver providers are audited annually. There is no random sample drawn for this population.

For the Autism waiver, 100% of providers are audited annually by the State operating agency Quality Assurance staff.

Waiver providers are contracted and credentialed by the MCO and bill the MCO directly for services rendered.

## Appendix I: Financial Accountability

### Quality Improvement: Financial Accountability

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

#### a. Methods for Discovery: Financial Accountability Assurance:

**The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program.** (For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")

##### i. Sub-Assurances:

**a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.**

(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

#### Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

#### Performance Measure:

Number and percent of clean claims that are paid by the managed care organization within the timeframes specified in the contract  
 $N = \text{Number of clean claims that are paid by the managed care organization within the timeframes specified in the contract}$   
 $D = \text{Total number of provider claims}$

**Data Source (Select one):****Other**

If 'Other' is selected, specify:

**DSS/DAI encounter data**

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
<b>Other</b> Specify: <div style="border: 1px solid black; padding: 5px; margin-top: 5px;">             KanCare Managed Care Organizations (MCOs)           </div>	<b>Annually</b>	<b>Stratified</b> Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b>	<b>Annually</b>

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
Specify:  <div style="border: 1px solid black; padding: 5px; margin: 5px;">           KanCare MCOs participate in analysis of this measure's results as determined by the State operating agency         </div>	
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:  <div style="border: 1px solid black; height: 30px; margin: 5px;"></div>

**b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.**

#### **Performance Measures**

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

#### **Performance Measure:**

Number and percent of payment rates that were certified to be actuarially sound by the State's actuary and approved by CMS N=number of payment rates that were certified to be actuarially sound by the State' actuary and approved by CMS D=Total number of capitation (payment) rates

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Rate Setting Documentation**

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach (check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b>

		<i>Confidence Interval =</i> <input type="text"/>
<i>Other Specify:</i>  <div>KanCare Managed Care Organizations (MCOs)</div>	<i>Annually</i>	<i>Stratified Describe Group:</i>  <input type="text"/>
	<i>Continuously and Ongoing</i>	<i>Other Specify:</i>  <input type="text"/>
	<i>Other Specify:</i>  <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<i>State Medicaid Agency</i>	<i>Weekly</i>
<i>Operating Agency</i>	<i>Monthly</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>
<i>Other Specify:</i>  <input type="text"/>	<i>Annually</i>
	<i>Continuously and Ongoing</i>
	<i>Other Specify:</i>  <input type="text"/>

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the

*State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.*

*The state established an interagency monitoring team to ensure effective interagency coordination as well as overall monitoring of MCO contract compliance. This work will be governed by the comprehensive state Quality Improvement Strategy for the KanCare program, a key component of which is the interagency monitoring team that engages program management, contract management and financial management staff of both KDHE and KDADS.*

*The MCOs are responsible for monitoring for ensuring that service plans are rendered appropriately as well as responsible for the payment to the provider.*

**b. Methods for Remediation/Fixing Individual Problems**

- i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.*

*These measures and collection/reporting protocols, together with others that are part of the KanCare MCO contract, are included in a statewide comprehensive KanCare quality improvement strategy which is regularly reviewed and adjusted. That plan is contributed to and monitored through a state interagency monitoring team, which includes program managers, contract managers, fiscal staff and other relevant staff/resources from both the state Medicaid agency and the state operating agency.*

*State staff request, approve, and assure implementation of contractor corrective action planning and/or technical assistance to address non-compliance with performance standards as detected through on-site monitoring, survey results and other performance monitoring. These processes are monitored by both contract managers and other relevant state staff, depending upon the type of issue involved, and results tracked consistent with the statewide quality improvement strategy and the operating protocols of the interagency monitoring team.*

**ii. Remediation Data Aggregation**

**Remediation-related Data Aggregation and Analysis (including trend identification)**

<b>Responsible Party</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:  <div style="border: 1px solid black; padding: 2px;">           KanCare Managed Care Organizations (MCOs)         </div>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:  <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

**c. Timelines**

*When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.*

**No**

**Yes**

*Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.*

## **Appendix I: Financial Accountability**

### **I-2: Rates, Billing and Claims (1 of 3)**

- a. Rate Determination Methods.** *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

*Under the KanCare comprehensive managed care program, capitation rates are established consistent with federal regulation requirements, by actuarially sound methods, which take into account utilization, medical expenditures, program changes and other relevant environmental and financial factors. The resulting rates are certified to and approved by CMS.*

*Under managed care, HCBS provider rates are determined through contracting with the MCO while the state sets actuarial sound capitation rates that are paid to the MCO for each Waiver beneficiary. The state sets the floor for the minimum rates that are required to be paid by the MCO, however. For the Autism Waiver, the State's floor rates are based on prior fee for service rates and are available through KMAP. Capitation rates are based on actuarial analysis of historical data for all Autism program services. These rates are based on historical claims and carried forward for KanCare Managed Care.*

*All waiver services are included in the capitation rates.*

- b. Flow of Billings.** *Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:*

*Claims for services are submitted to the MCOs directly from waiver provider agencies delivering Autism waiver services. All claims are either submitted through the MMIS portal, the State's front end billing solution or directly to the MCO either submitted through paper claim format or through electronic format. Capitated payments in arrears are made only when the participant was eligible for the Medicaid waiver program during the month.*

## **Appendix I: Financial Accountability**

### **I-2: Rates, Billing and Claims (2 of 3)**

- c. Certifying Public Expenditures (select one):**

**No.** *state or local government agencies do not certify expenditures for waiver services.*

**Yes.** *state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.*

**Select at least one:**

**Certified Public Expenditures (CPE) of State Public Agencies.**

*Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-a.)*

***Certified Public Expenditures (CPE) of Local Government Agencies.***

*Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)*

## ***Appendix I: Financial Accountability***

### ***I-2: Rates, Billing and Claims (3 of 3)***

- d. Billing Validation Process.*** Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

*A capitated payment is made to the MCOs for each month of Waiver eligibility. This is identified through KAECS, the State's eligibility system.*

*Post payment billings are conducted by the MCOs.*

*The State's Quality Management Staff (QMS) conducts quarterly and annual reviews, which includes reviewing case file documentation to see if Choice was provided and if the participant signed the Choice document. Additionally, participant interviews have been completed, inquiring if they were provided Choice. During the interview of the participant QMS identifies if a provider choice form was presented to the family, asks how the provider choice was decided and if services were rendered according to those identified on the participant's POC.*

- e. Billing and Claims Record Maintenance Requirement.*** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

## ***Appendix I: Financial Accountability***

### ***I-3: Payment (1 of 7)***

- a. Method of payments -- MMIS (select one):***

***Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).***

***Payments for some, but not all, waiver services are made through an approved MMIS.***

*Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures*

on the CMS-64:

***Payments for waiver services are not made through an approved MMIS.***

*Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:*

***Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.***

*Describe how payments are made to the managed care entity or entities:*

*The MMIS Managed Care system assigns beneficiaries to one of the three KanCare Plans. Each assignment generates an assignment record, which is shared with the plans via an electronic record. At the end of each month, the MMIS Managed Care System creates a capitation payment, paid in arrears, for each beneficiary who was assigned to one of the plans. Each payment is associated to a rate cell. The rate cells, defined by KDHE as part of the actuarial rate development process which is certified to and approved by CMS, each have a specific dollar amount established by actuarial data for a specific cohort and an effective time period for the rate.*

## ***Appendix I: Financial Accountability***

### ***I-3: Payment (2 of 7)***

***b. Direct payment.*** *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

***The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.***

***The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.***

***The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.***

*Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:*

***Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.***

*Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.*

*All of the waiver services in this program are included in the state's contract with the KanCare MCOs.*



**Appendix I: Financial Accountability****I-3: Payment (3 of 7)**

**c. Supplemental or Enhanced Payments.** Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:

**No. The state does not make supplemental or enhanced payments for waiver services.**

**Yes. The state makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

**Appendix I: Financial Accountability****I-3: Payment (4 of 7)**

**d. Payments to state or Local Government Providers.** Specify whether state or local government providers receive payment for the provision of waiver services.

**No. State or local government providers do not receive payment for waiver services. Do not complete Item I-3-e.**

**Yes. State or local government providers receive payment for waiver services. Complete Item I-3-e.**

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

**Appendix I: Financial Accountability****I-3: Payment (5 of 7)**

**e. Amount of Payment to State or Local Government Providers.**

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

**Answers provided in Appendix I-3-d indicate that you do not need to complete this section.**

**The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.**

**The amount paid to state or local government providers differs from the amount paid to private providers of**

*the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.*

*The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.*

Describe the recoupment process:

## Appendix I: Financial Accountability

### I-3: Payment (6 of 7)

**f. Provider Retention of Payments.** Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:

*Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.*

*Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.*

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

No. The monthly capitated payments to the MCOs are not reduced or returned in part to the state.

## Appendix I: Financial Accountability

### I-3: Payment (7 of 7)

#### g. Additional Payment Arrangements

**i. Voluntary Reassignment of Payments to a Governmental Agency.** Select one:

*No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.*

*Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).*

Specify the governmental agency (or agencies) to which reassignment may be made.

**ii. Organized Health Care Delivery System.** Select one:

*No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.*

*Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.*

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for

designation as an OHCDs; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDs; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDs arrangement is employed, including the selection of providers not affiliated with the OHCDs; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDs meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDs contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDs arrangement is used:

**iii. Contracts with MCOs, PIHPs or PAHPs.**

***The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.***

***The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.***

*Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.*

***This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.***

***This waiver is a part of a concurrent ?1115/?1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The ?1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***

***If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.***

*In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.*

## **Appendix I: Financial Accountability**

### **I-4: Non-Federal Matching Funds (1 of 3)**

**a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:

***Appropriation of State Tax Revenues to the State Medicaid agency******Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.***

*If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:*

*The non-federal share of the waiver expenditures is from direct state appropriations to the Department for Aging and Disability Services (KDADS), through agreement with the Single State Medicaid Agency, Kansas Department of Health and Environment (KDHE), as of July 1, 2012. The non-federal share of the waiver expenditures are directly expended by KDADS. Medicaid payments are processed by the State's fiscal agent through the Medicaid Management Information System using the InterChange STARS Interface System (iCSIS). iCSIS contains data tables with the current federal and state funding percentages for all funding types. State agencies are able to access iCSIS's reporting module to identify payments made by each agency. KDHE – Division of Health Care Finance draws down federal Medicaid funds for all agencies based on the summary reports from iCSIS. Interfund transfers to the other state agencies are based on finalized fund summary reports. The full rate will be expended on capitation payments in the KanCare program.*

***Other State Level Source(s) of Funds.***

*Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:*

***Appendix I: Financial Accountability******I-4: Non-Federal Matching Funds (2 of 3)***

***b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.*** *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

***Not Applicable.*** *There are no local government level sources of funds utilized as the non-federal share.*

***Applicable***

*Check each that applies:*

***Appropriation of Local Government Revenues.***

*Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:*

***Other Local Government Level Source(s) of Funds.***

*Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an*

*Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:*

## **Appendix I: Financial Accountability**

### **I-4: Non-Federal Matching Funds (3 of 3)**

**c. Information Concerning Certain Sources of Funds.** *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

*None of the specified sources of funds contribute to the non-federal share of computable waiver costs*

*The following source(s) are used*

*Check each that applies:*

*Health care-related taxes or fees*

*Provider-related donations*

*Federal funds*

*For each source of funds indicated above, describe the source of the funds in detail:*

## **Appendix I: Financial Accountability**

### **I-5: Exclusion of Medicaid Payment for Room and Board**

**a. Services Furnished in Residential Settings.** *Select one:*

*No services under this waiver are furnished in residential settings other than the private residence of the individual.*

*As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.*

**b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** *The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:*

**Do not complete this item.**

## **Appendix I: Financial Accountability**

### **I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver**

**Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver.** *Select one:*

*No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.*

*Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can*

*be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.*

*The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:*

## **Appendix I: Financial Accountability**

### **I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)**

**a. Co-Payment Requirements.** *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

**No.** *The state does not impose a co-payment or similar charge upon participants for waiver services.*

**Yes.** *The state imposes a co-payment or similar charge upon participants for one or more waiver services.*

**i. Co-Pay Arrangement.**

*Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):*

**Charges Associated with the Provision of Waiver Services** (if any are checked, complete Items I-7-a-ii through I-7-a-iv):

*Nominal deductible*

*Coinsurance*

*Co-Payment*

*Other charge*

*Specify:*

## **Appendix I: Financial Accountability**

### **I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)**

**a. Co-Payment Requirements.**

**ii. Participants Subject to Co-pay Charges for Waiver Services.**

**Answers provided in Appendix I-7-a indicate that you do not need to complete this section.**

## **Appendix I: Financial Accountability**

### **I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)**

**a. Co-Payment Requirements.****iii. Amount of Co-Pay Charges for Waiver Services.**


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*Answers provided in Appendix I-7-a indicate that you do not need to complete this section.*

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**Appendix I: Financial Accountability****I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)****a. Co-Payment Requirements.****iv. Cumulative Maximum Charges.**


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*Answers provided in Appendix I-7-a indicate that you do not need to complete this section.*

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**Appendix I: Financial Accountability****I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)****b. Other State Requirement for Cost Sharing.** Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:

**No.** The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.

**Yes.** The state imposes a premium, enrollment fee or similar cost-sharing arrangement.

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

**Appendix J: Cost Neutrality Demonstration****J-1: Composite Overview and Demonstration of Cost-Neutrality Formula**

**Composite Overview.** Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

**Level(s) of Care:** Hospital

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	1250.07	12215.44	13465.51	34500.00	15500.00	50000.00	36534.49
2	1250.07	12215.44	13465.51	34500.00	15500.00	50000.00	36534.49
3	1250.07	12215.44	13465.51	34500.00	15500.00	50000.00	36534.49
4	1250.07	12215.44	13465.51	34500.00	15500.00	50000.00	36534.49
5	1250.07	12215.44	13465.51	34500.00	15500.00	50000.00	36534.49

**Appendix J: Cost Neutrality Demonstration**

**J-2: Derivation of Estimates (1 of 9)**

- a. Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

**Table: J-2-a: Unduplicated Participants**

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		Hospital	
Year 1	82		82
Year 2	82		82
Year 3	82		82
Year 4	82		82
Year 5	82		82

**Appendix J: Cost Neutrality Demonstration****J-2: Derivation of Estimates (2 of 9)**

- b. Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

Average Length of Stay is 290 days for each year of the renewal.

This is calculated based off of the turnover rate, which is the total number of unduplicated persons per year divided by the number of persons served at any point in time:  $82/65 = 1.26$ . The average length of stay is 365 days divided by the turnover rate of 1.26, which equals = 290 days. Since the point-in-time limit is the same for all 5 years, the ALOS is 290 days for each year of the renewal.

**Appendix J: Cost Neutrality Demonstration****J-2: Derivation of Estimates (3 of 9)**

- c. Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

- i. Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:

Factor D was estimated by evaluating experience and analyzing data from the Kansas MMIS system and reflects MCO payments to providers for CY15, 01/01/2015 to 12/31/2015. This will only be a projection of MOC encounters and not be reflective of the State's Capitation payments to the MCO. This average expenditure was used to project Years 1 through 5 of the waiver. Utilization for the group services was assumed to be utilized by 50% of clients at 100% of the allowed amount.

- ii. Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor D' was projected by the average AU waiver capitation cost for CY15 (01/01/2015 to 12/31/2015) minus the MCO encounter payment cost for CY2015 (01/01/2015 to 12/31/2015).

- iii. Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:



Factor G was estimated and reflects the average institutional cost and utilization for children in the replacement facilities for the former state hospitals for children for the Federal Fiscal Year 2015 (10/1/2014 to 09/30/2015).

- iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G' was estimated and reflects the average acute care cost and utilization for children in replacement facilities for the former state hospitals for children for the Federal Fiscal Year 2015 (10/1/2014 to 09/30/2015).

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (4 of 9)

**Component management for waiver services.** If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.

Waiver Services	
Respite Care	
Family Adjustment Counseling	
Parent Support and Training (peer to peer) Provider	

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (5 of 9)

#### d. Estimate of Factor D.

ii. **Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937).** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

#### Waiver Year: Year 1

Waiver Service/Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Respite Care Total:</b>							38016.00
Respite Care		15 minutes	80	160.00	2.97	38016.00	
<b>Family Adjustment Counseling Total:</b>							34651.20
Group		15 minutes	40	120.00	5.00	24000.00	
<b>GRAND TOTAL:</b>							102505.52
Total: Services included in capitation:							102505.52
Total: Services not included in capitation:							
Total Estimated Unduplicated Participants:							82
Factor D (Divide total by number of participants):							1250.07
Services included in capitation:							1250.07
Services not included in capitation:							
Average Length of Stay on the Waiver:							290

Waiver Service/Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Individual		15 minutes	80	14.00	9.51	10651.20	
Parent Support and Training (peer to peer) Provider Total:							29838.32
Individual		15 minutes	80	51.10	5.89	24078.32	
Group		15 minutes	40	48.00	3.00	5760.00	
<b>GRAND TOTAL:</b> Total: Services included in capitation: Total: Services not included in capitation: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Services included in capitation: Services not included in capitation: Average Length of Stay on the Waiver:							102505.52 102505.52 82 1250.07 1250.07 290

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (6 of 9)

#### d. Estimate of Factor D.

ii. **Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

#### Waiver Year: Year 2

Waiver Service/Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Care Total:							38016.00
Respite Care		15 minutes	80	160.00	2.97	38016.00	
Family Adjustment Counseling Total:							34651.20
Group		15 minutes	40	120.00	5.00	24000.00	
<b>GRAND TOTAL:</b> Total: Services included in capitation: Total: Services not included in capitation: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Services included in capitation: Services not included in capitation: Average Length of Stay on the Waiver:							102505.52 102505.52 82 1250.07 1250.07 290

Waiver Service/Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Individual		15 minutes	80	14.00	9.51	10651.20	
Parent Support and Training (peer to peer) Provider Total:							29838.32
Individual		15 minutes	80	51.10	5.89	24078.32	
Group		15 minutes	40	48.00	3.00	5760.00	
<b>GRAND TOTAL:</b> Total: Services included in capitation: Total: Services not included in capitation: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Services included in capitation: Services not included in capitation: Average Length of Stay on the Waiver:							102505.52 102505.52 82 1250.07 1250.07 290

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (7 of 9)

#### d. Estimate of Factor D.

ii. **Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

#### Waiver Year: Year 3

Waiver Service/Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Care Total:							38016.00
Respite Care		15 minutes	80	160.00	2.97	38016.00	
Family Adjustment Counseling Total:							34651.20
Group		15 minutes	40	120.00	5.00	24000.00	
<b>GRAND TOTAL:</b> Total: Services included in capitation: Total: Services not included in capitation: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Services included in capitation: Services not included in capitation: Average Length of Stay on the Waiver:							102505.52 102505.52 82 1250.07 1250.07 290

Waiver Service/Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Individual		15 minutes	80	14.00	9.51	10651.20	
Parent Support and Training (peer to peer) Provider Total:							29838.32
Individual		15 minutes	80	51.10	5.89	24078.32	
Group		15 minutes	40	48.00	3.00	5760.00	
<b>GRAND TOTAL:</b> Total: Services included in capitation: Total: Services not included in capitation: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Services included in capitation: Services not included in capitation: Average Length of Stay on the Waiver:							102505.52 102505.52 82 1250.07 1250.07 290

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (8 of 9)

#### d. Estimate of Factor D.

**ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

#### Waiver Year: Year 4

Waiver Service/Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Care Total:							38016.00
Respite Care		15 minutes	80	160.00	2.97	38016.00	
Family Adjustment Counseling Total:							34651.20
Group		15 minutes	40	120.00	5.00	24000.00	
<b>GRAND TOTAL:</b> Total: Services included in capitation: Total: Services not included in capitation: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Services included in capitation: Services not included in capitation: Average Length of Stay on the Waiver:							102505.52 102505.52 82 1250.07 1250.07 290

Waiver Service/Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Individual		15 minutes	80	14.00	9.51	10651.20	
Parent Support and Training (peer to peer) Provider Total:							29838.32
Individual		15 minutes	80	51.10	5.89	24078.32	
Group		15 minutes	40	48.00	3.00	5760.00	
<b>GRAND TOTAL:</b> Total: Services included in capitation: Total: Services not included in capitation: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Services included in capitation: Services not included in capitation: Average Length of Stay on the Waiver:							102505.52 102505.52 82 1250.07 1250.07 290

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (9 of 9)

#### d. Estimate of Factor D.

**ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

#### Waiver Year: Year 5

Waiver Service/Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Care Total:							38016.00
Respite Care		15 minutes	80	160.00	2.97	38016.00	
Family Adjustment Counseling Total:							34651.20
Group		15 minutes	40	120.00	5.00	24000.00	
<b>GRAND TOTAL:</b> Total: Services included in capitation: Total: Services not included in capitation: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Services included in capitation: Services not included in capitation: Average Length of Stay on the Waiver:							102505.52 102505.52 82 1250.07 1250.07 290

<i>Waiver Service/ Component</i>	<i>Capi-tation</i>	<i>Unit</i>	<i># Users</i>	<i>Avg. Units Per User</i>	<i>Avg. Cost/ Unit</i>	<i>Component Cost</i>	<i>Total Cost</i>
<i>Individual</i>		15 minutes	80	14.00	9.51	10651.20	
<b>Parent Support and Training (peer to peer) Provider Total:</b>							29838.32
<i>Individual</i>		15 minutes	80	51.10	5.89	24078.32	
<i>Group</i>		15 minutes	40	48.00	3.00	5760.00	
<b>GRAND TOTAL:</b>							102505.52
<i>Total: Services included in capitation:</i>							102505.52
<i>Total: Services not included in capitation:</i>							
<i>Total Estimated Unduplicated Participants:</i>							82
<i>Factor D (Divide total by number of participants):</i>							1250.07
<i>Services included in capitation:</i>							1250.07
<i>Services not included in capitation:</i>							
<i>Average Length of Stay on the Waiver:</i>							290